Namibia Capacity Building for Country Owned HIV/AIDS Services

FY 2013 Quarter 4
(July - September 2013)
and
Annual Program Progress Report
(October 2012 – September 2013)

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMS	Anglican Medical Services
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BMI	Body Mass Index
C&T	Care and Treatment
CAA	Catholic AIDS Action
CBO	Community-Based Organization
CCN	Council of Churches in Namibia
CDC	Centers for Disease Control and Prevention
CHS	Catholic Health Services
CM	Community Mobilizers
CTP	Cotrimoxazole Prophylaxis
DAPP	Development AID from People to People
ELCAP	Evangelical Lutheran Church AIDS Program
ELISA	Enzyme-Linked Immunosorbent Assay
EMIS	Education Management Information System
EmOC	Emergency Obstetric Care
EMTCT	Elimination of Mother-to-Child Transmission of HIV
ePMS	Electronic Patient Management System (FileMaker Data System)
EQA	External Quality Assurance
FBO	Faith-Based Organization
FBH	Faith-Based Hospital
FP	Family Planning
GRN	Government Republic Namibia
HCMS	Human Capacity Management System
HCS	HIV Clinicians' Society
HIV	Human Immunodeficiency Virus
HRMIS	Human Resource Management Information Systems (MoHSS Sub Division)
HRIMS	Human Resource Information Management System (Office of the Prime Minister)
HRIS	Human Resources Information System
HCT	HIV Counseling and Testing
IMAI	Integrated Management of Adolescent and Adult Illness
IPT	INH Preventive Therapy
IT	Information Technology
LL/CL	LifeLine/ChildLine
LMS	Lutheran Medical Services
MARP	Most-At-Risk Population
MC	Male Circumcision
MCP	Multiple Concurrent Partnership
M&E	Monitoring and Evaluation
MIS	Management Information System
MNCH	Maternal, Newborn and Child Health
MoHSS	Ministry of Health and Social Services
MOU	Memorandum of Understanding
NDF	National Defense Forces
NFS	National Strategic Framework
NIP	Namibia Institute of Pathology
NLT	NawaLife Trust
NRCS	Namibia Red Cross Society
NS	New Start
OPD	Out Patient Department
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health, Dignity and Prevention
PI	Performance Improvement
PITC	Provider-Initiated Testing and Counseling
PLHIV	Person Living with HIV and AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PO	HIV Prevention Officer
PwP	Prevention with Positives
QA	Quality Assurance
RDQA	Rapid Data Quality Assessment
RMT	Regional Management Team
RT	Rapid Testing
RTK	Rapid Test Kit
SBCC	Social Behavior Change Communications
SCMS	Supply Chain Management Systems
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TB	Tuberculosis

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TA
TB

TWG	Technical Working Group	VCT	(HIV) Voluntary Counseling and Testing
USAID	United States Agency for International Development	VMMC	Voluntary Medical Male Circumcision

Program Results (required)

See Excel spreadsheet ("INTRAHEALTH FY13 APR Results (Oct.12-Sep.13) and complete worksheet on table of program results.

2013 Program Summary:

FY2013 was in many instances a flagship year for IntraHealth Namibia. It marked the end of our sub-award agreements under the Namibian Associate Cooperative Agreement and all the USG-funded nurses (except for LMS), doctors, pharmacists and pharmacy assistants have been successfully absorbed and their salaries are now being paid by our FBO partners with funding from the Ministry of Health and Social Services (MoHSS) thereby realizing our focus on the Global Health Initiative principles of local ownership, sustainability, evidenced-based approaches, innovation and services integration.

Enhanced clinical HIV service delivery within Namibia: IntraHealth used the Performance Improvement (PI) approach to identify reasons for performance gaps in emergency obstetric and neonatal care (EmONC) and develop interventions to address them and made plans to monitor the effect of these efforts. The latter complements IntraHealth's close collaboration with the MoHSS PHC Directorate regarding EmONC/LSS activities which include EmONC/LSS training, supportive and supervisory visits as well as participating in the design of maternity waiting homes. IntraHealth also met with WHO to discuss collaboration within the maternal and child health areas.

95% of the mothers who delivered in the faith-based hospitals had known HIV statuses. MoHSS requested IntraHealth's assistance in developing a concept note for a mother to mother (M2M) support group program as part of the mother to child transmission (EMTCT) agenda. IntraHealth conducted a study tour on M2M to learn from the Ethiopian IntraHealth program and completed a concept note and implementation plan for M2M for Namibia as a result of that. The training curriculum had also been modified for the Namibian situation.

In collaboration with MoHSS, I-TECH and SHOPS, IntraHealth developed the Male Circumcision for private practitioners. In the last quarter of this year, only one site, Onandjokwe hospital received supported from IntraHealth in the provision of VMMC. The OGAC suspension of spending on MC activities negatively affected this program area this past year.

IntraHealth continued to provide technical assistance to Society for Family Health on sexual and other behavioral risk prevention techniques which included strengthening the referral between programs for key populations and health facilities.

IntraHealth continued to support Counseling and Testing programs at the faith based facilities and focuses specifically on expanding HCT services using mixed models. With our support, 3 faith based hospitals successfully rolled out PITC at OPD and wards. In support of the GHI objectives, the IntraHealth M&E tools for HCT were transitioned to the MoHSS register to collect information. Lifeline/Childline CBD and CCN New start centers were integrated.

The pilot for the bi-directional referral system was finalized and the final evaluation report presented to the Division of Special Programs (DSP) at MoHSS.

Interventions targeting health system strengthening with a specific focus on improving human resources for health

IntraHealth engaged the University of Namibia (UNAM) to assist MoHSS to finalize a study conducted in 2010 to identify incentives to attract and retain health professionals. To date the analysis was finalized and the report presented to the Human Resources Development (HRD) Division and the Restructuring Committee at MoHSS.

IntraHealth completed a National Workload Indicator Staffing Norm (WISN) using a WHO tool, the first time ever the tool had been used at a national level. The WISN was done for Nurses, Doctors, Pharmacists and Pharmacy Assistants at all public sector health facilities, including faith based facilities. This resulted in several recommendations made to MoHSS via the Restructuring Committee and the MoHSS Strategic Planning Retreat which includes policy level to support MoHSS restructuring efforts and revise staffing norms. These results were also presented at a USAID meeting in Washington in May 2013 in addition to other transition activities.

IntraHealth continued to support MoHSS to fully operationalize the HCMS through providing support to train 52 HR staff in 13 regions on the use of HCMS. Since the HCMS data only included human resources information from the MoHSS, IntraHealth supported the adaptation of the iHRIS Manage into all faith based hospitals. This was completed for LMS thus far and work started on implementing the system for AMS and CHS in the next year.

IntraHealth engaged with the Health Professions Council of Namibia (HPCNA) to provide technical assistance to review their current data management system, identify gaps in using the system to provide accurate and timely information on the status of health workers in Namibia and provide solutions to close the gaps. As a result IntraHealth interviewed users from the 5 councils and departments to record their requirements which will be used as the basis for assessing their current system.

Program-Area Narratives for October 2012 – September 2013

2.1. Program Area 1: Prevention of Mother-to-Child Transmission of HIV (PMTCT) and Maternal, Newborn and Child Health (MNCH)

Through its PMTCT work, IntraHealth focuses on reducing the incidence of vertical transmission of HIV by providing antiretroviral (ARV) prophylaxis to more HIV-positive women and their babies who are exposed to the virus. We provided PMTCT technical assistance at antenatal clinics and labor and delivery wards in six faith-based facilities (five hospitals and one health center). To help reach the MoHSS's goal to eliminate mother-to-child transmission, IntraHealth encourages a four-pronged approach: 1) prevent HIV infection among women of reproductive age; 2) prevent unintended pregnancies by providing family planning services; 3) prevent women living with HIV from passing the virus to their infants; 4) provide appropriate treatment, care, and support to mothers living with HIV, their children, and their families.

In addition to our PMTCT work, IntraHealth helped FBHs, Erongo and the Kavango regions to improve emergency obstetric care and reduce maternal and neonatal mortality.

By the end of the reporting period, IntraHealth was helping to improve PMTCT services in 56 facilities in and around mission facilities. These sites include the six faith-based facilities cited above plus 50 in surrounding communities that fall under our partners' management (though not all are faith-based). Only seven facilities within this catchment area are not yet offering PMTCT. But IntraHealth will continue to work with our partners to reach 100% PMTCT coverage, helping Namibia to achieve its national goal to eliminate mother-to-child HIV transmission.

AMS and CHS PMTCT program has been transitioned to GRN subsidy through transition of nurses, doctors and pharmacy staff, direct support is still provided to LMS Onandjokwe district during the fourth quarter of FY13.

Accomplishments & Successes

Maternal, Neonatal, and Child Health

- IntraHealth procured and delivered emergency obstetric equipment for the FBHs during the previous quarters. These include an ultrasound scan, fetal dopplers, vacuum extractors, hemoglobin meters, and five cardio-tocographs and autoclaves for Onandjokwe and Nyangana.

- After the emergency obstetric and neonatal care (EmONC)/LSS training in Kavango during the last quarter of FY12, IntraHealth continued to provide technical assistance to the Kavango RMT

in FY13. We used the performance improvement (PI) approach to define the existing performance gaps, develop interventions to address them, and make plans to monitor the effect of these efforts.

- IntraHealth supported one medical officer from Andara who is currently undergoing a 3 month anesthesia training in Oshakati. It is anticipated that on completion, Andara should be able to conduct most of the emergency obstetric and gynecological surgical procedures and reduce the number of referrals to Rundu. One medical officer from Nyangana completed two month anesthesia training and remained with one month to complete the course during the first quarter FY14

- IntraHealth supported two staff from Onandjokwe and they completed their two month attachment/training in neonatology

- The maternal and neonatal mortality survey in Erongo, Khomas, Omaheke, Hardap, and Karas regions is progressing well. Data collection has been completed and data analysis and report writing is in progress. The report will be finalized during the following quarters in FY14

- IntraHealth Namibia conducted a study tour to Ethiopia Mother Support Group (MSG) program implemented by IntraHealth. The concept note has since been revised to incorporate the lessons learnt from Ethiopia and suggestions from the Kavango RMT where a pilot is being proposed. The Kavango RMT has shown keen interest in piloting this program in select districts within the region. A baseline assessment is planned for next quarter and an official letter of request to pilot the program will be sent to the Permanent Secretary of MoHSS.

- IntraHealth provided financial and technical support for the annual zonal/ inter-regional forum for maternal, perinatal and neonatal death reviews. The forum included 7 regions namely Oshikoto, Omusati, Oshana, Ohangwena, Otjozondjupa, Kunene and Kavango. It was attended by RMTs and staff from the district and intermediate hospitals. IntraHealth will support trainings in EmOC/ LSS and implementation of PIA in 2 priority regions to be identified by MoHSS.

- IntraHealth held a meeting with World Health Organization (WHO) to identify areas for collaboration within the maternal and child health areas. WHO is receiving a 10 million Euro grant to support comprehensive MCH activities to reduce maternal, neonatal and child mortality and morbidity in 6 districts. Some of the potential areas for collaboration identified include EmOC/LSS training and follow up and development of e-learning materials for EmOC/ LSS.

- Kavango and Erongo RMTs and the trainers conducted follow-up visits to fourteen facilities using IntraHealth-developed checklist, to assess staff and facility performance; availability of essential medicines and supplies; and staff knowledge of prevention, identification, and management of obstetric and newborn complications. The visits revealed some key gaps:

- Many partographs are incomplete and misinterpreted because staff lack knowledge and skills on how to plot and interpret the parameters on the partograph.
- Some staff lack knowledge and skills on managing obstetric complications.
- Midwives who are trained in emergency obstetric care are rotated frequently.

To make sure these health workers have the knowledge and skills they need, IntraHealth developed site-specific interventions—and timelines to measure progress—for each facility. We created plans to retain trained staff in obstetric departments, orient staff on partograph protocols, provide continuous on-the-job training for staff that manage obstetric and newborn complications, and conduct monthly audits to enhance patient management. During the second and third round of visits, IntraHealth assessed the Kavango facilities' progress on these interventions. The graphs below demonstrate the progress made and challenges experienced per facility:

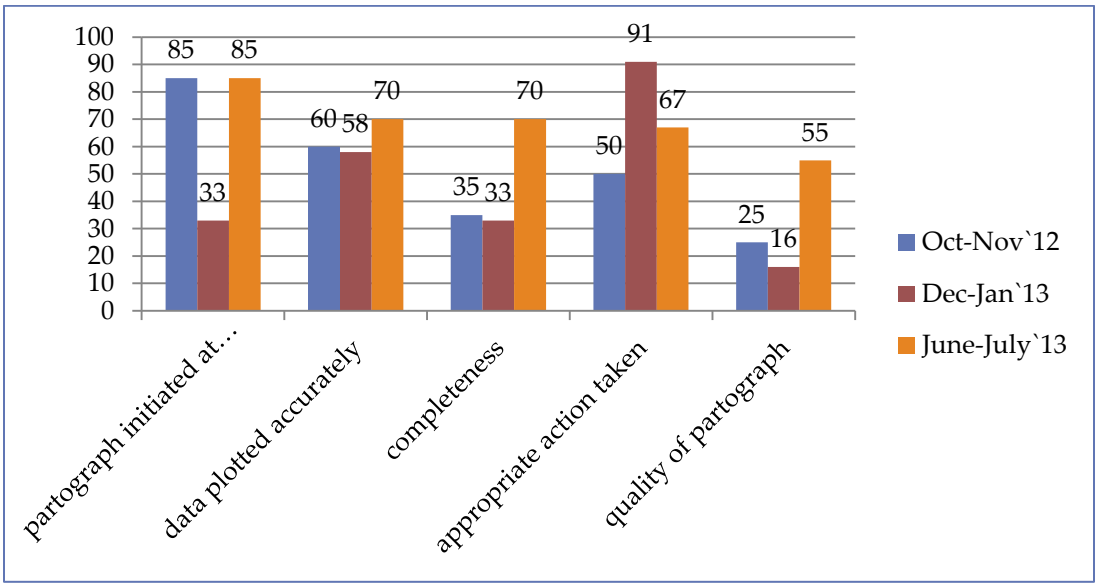


Figure 1: Andara performance

After the training and the first follow-up visit, Andara did not implement the planned interventions. In addition, the nurse in charge in maternity was also resistant to initiating partographs during the latent phase of labor and thus the decline in performance was mainly affected by partographs not initiated on time and completeness. The same nurse was not trained in the current EmOC/ LSS guidelines and she was also not present during the initial implementation of EmOC/ LSS. As a result, performance declined in almost all the areas when she came back on duty, as shown in Figure 1, Dec-Jan`13. During the second visit, she was convinced of the rationale for initiating partographs during the latent and completeness. Drastic improvement is noted during the third visit (June-July`13).

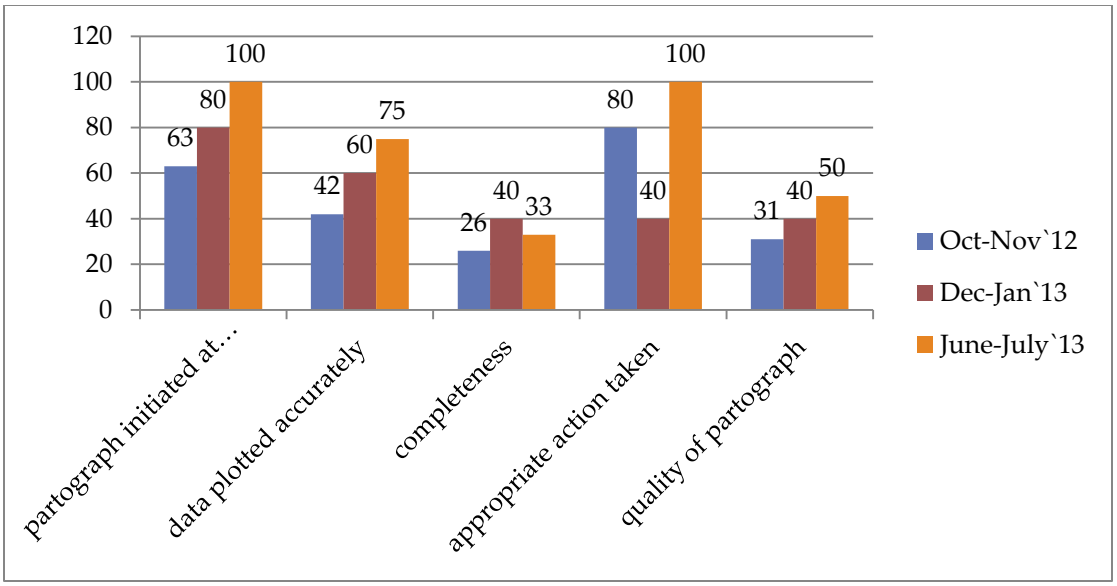


Figure 2: Nankudu performance

After Nankudu made efforts to implement interventions according to the agreed action plan, performance improved in most of the areas (see Figure 2). The decline in performance for appropriate action taken was due to the fact that no orientation was done to night duty staff and most of the files reviewed had prolonged labor which was not acted on time. In fact the prolonged labor was only picked up by day staff. Management support was lacking during the second visit Dec-Jan`13, but now the management team has demonstrated their willingness and improved in this area and facilitated orientation and feedback to night duty staff.

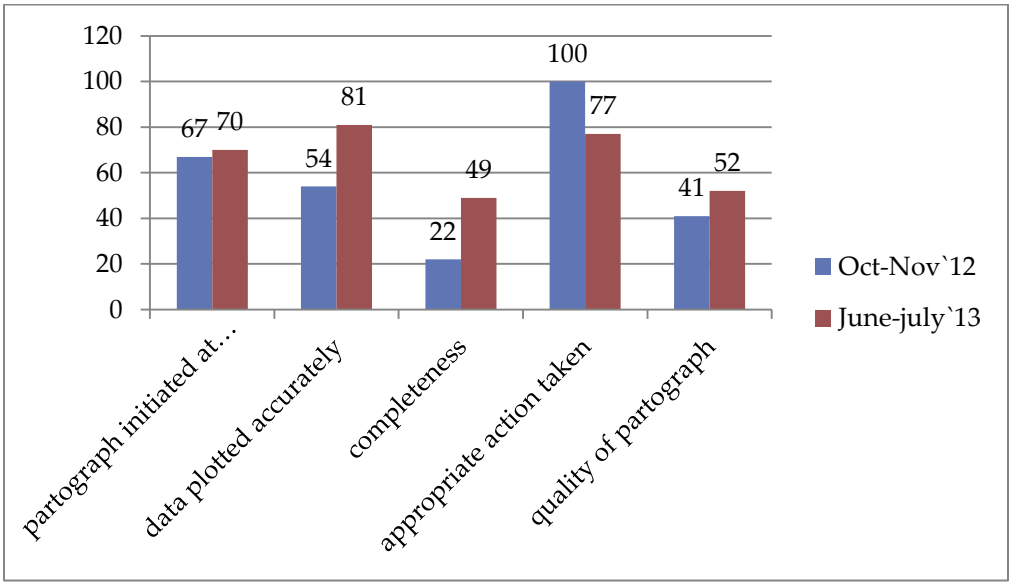


Figure 3: Rundu Intermediate Hospital performance

Rundu made progress and showed commitment to implementing the interventions based on the agreed action plan. The management has fully embraced EmONC/LSS, and as a result, their performance improved in all the areas except appropriate action taken because staff lacks knowledge and skills on how to plot and interpret the parameters on the partograph. (See Figure 3)

- IntraHealth collaborated with the MOHSS PHC Directorate, Erongo RMT to train health workers on EmONC/LSS in Swakopmund. All the trainers were drawn from the pool of local certified ToT's. Prior to EMOC training, agreement was reached with RMT and facility managers to not rotate staff out of the maternity unity after EMOC training to improve quality of care and staff retention in this highly specialized area.

- A total of 20 managers including the RMT were oriented in EmONC/LSS and this one-week orientation for managers was followed by two-week EmONC/LSS training. A total of 22 staff were trained (includes 21 midwives and one doctor). One-week focused antenatal care training was also conducted. Following the training, a follow-up plan was developed with the Erongo RMT, trainers, PHC Directorate, and IntraHealth.

- After the emergency obstetric and neonatal care (EmONC)/LSS training in Erongo during the second quarter of FY13, IntraHealth continued to provide technical and financial assistance to the Erongo RMT to conduct two follow up support and supervisory visits to the 4 district hospitals. The first follow up took place in June 2013 and the second one in September 2013. We used the performance improvement (PI) approach to define the existing performance gaps, develop interventions to address them, and make plans to monitor the effect of these efforts. The support visits identified a number of gaps including the use of the partograph and neonatal resuscitation. Each facility developed an action plan to close these gaps which will be monitored over time and during subsequent visits. The follow up visits were led by the Erongo RMT.

- Based on recommendations from an assessment by the MoHSS and WHO in FY12, IntraHealth helped to create guidelines and designs for maternity waiting homes in Namibia. We have provided drafts to the PHC director, whose feedback will shape the final versions. These guidelines will help standardize maternity waiting homes and the services they provide.

- IntraHealth participated in the review and finalization of the PMTCT guidelines and the operational plan for the phased implementation of Option B+. The first phase will take place in March 2014.

- Participated in the finalization of mother-baby follow up system which was piloted in the four regions

- While IntraHealth has received the letter on mortality data from the MoHSS, it instructed us to collect no additional data outside what we are currently collecting in HIS. Instead it encouraged

IntraHealth to work through the HIS TWG to incorporate comprehensive EmONC indicators. IntraHealth will continue to partner with the MoHSS HIS TWG to revise the indicators.

- During the next quarter, IntraHealth will finalize a report on the completion of the dual protection tool pilot.

Antenatal Care

During the fourth quarter, 1,111 women attended a first ANC visit. Of those, 134 (12%) started ANC with known HIV-positive statuses and 977 (88%) started with unknown HIV statuses. Of those mothers with unknown HIV statuses, 881 (90%) were newly tested in the fourth quarter and received their HIV test results.

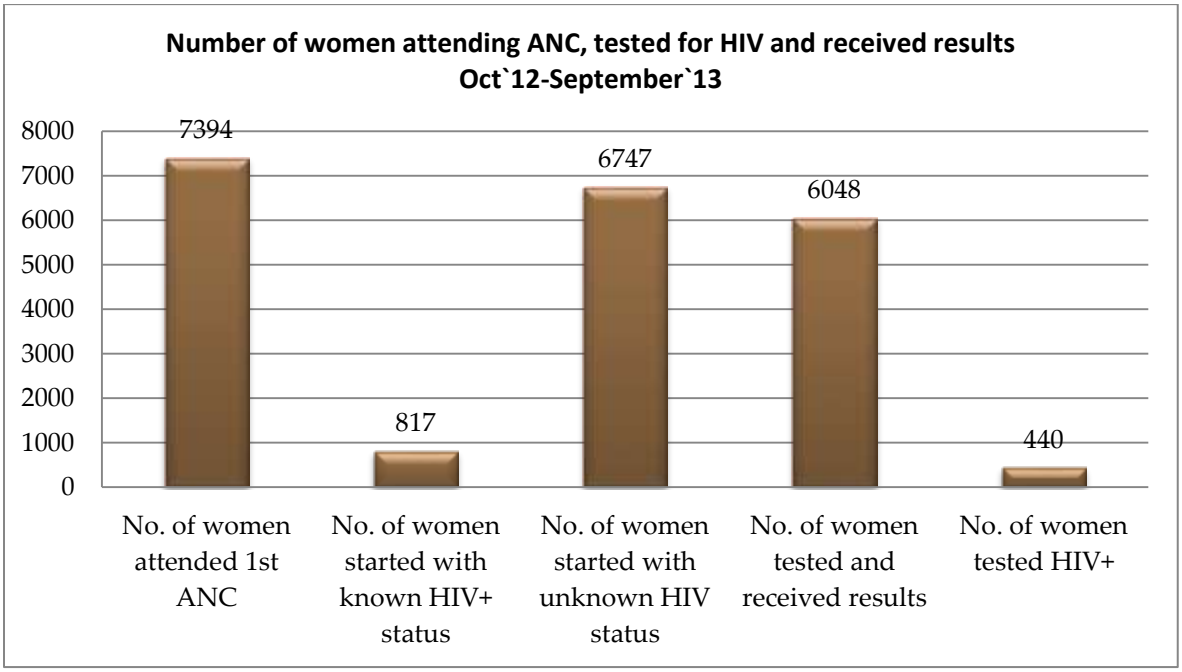


Figure 4: Number of women attending ANC, tested for HIV and received results Oct`12-September`13

During FY13 7,394 women attended a first ANC visit. Of those, 817 (11%) started ANC with known HIV-positive status and 6747 (91%) started with unknown HIV statuses. Of those mothers with unknown HIV statuses, 6,048 (90%) were newly tested and received their results in FY13. The total number of pregnant women with known HIV statuses is 6,865.

Of the total pregnant women counseled and tested during fourth quarter, 66 (7%) tested HIV positive, bringing the total for the FY13 to 440 (6%). These numbers include women who attended ANC at

peripheral clinics within mission-supported districts that are receiving indirect support from IntraHealth.

As part of the couples' counseling program within PMTCT, 72 (6%) of the 1,111 women counseled and tested were tested along with their partners during quarter four. During FY13, 6048 women were counseled and tested; of those, 333 (5%) were tested along with their partners. Of the 72 men tested during quarter four, 6 (8%) tested HIV positive, creating an annual total of 29 men who tested positive. All women who tested HIV positive were referred for enrollment into HIV care and assessment for treatment. Women who tested HIV negative before the third trimester were counseled on prevention and encouraged to take a repeat test during the last trimester.

Labor & Delivery

Of the 1,729 women who delivered their babies in IntraHealth-supported health facilities during Q4, FY13, 1,674 (97%) knew their HIV statuses. During the same period, 267 HIV-positive women delivered in these facilities—188 (70%) received ART and 79 (34%) received ARV prophylaxis—and 258 newborns received ARV prophylaxis. Most (100%) HIV-positive women said they preferred exclusive breastfeeding for their infants.

During FY13, 8,202 women delivered at IntraHealth-supported facilities. Of these, 7,888 (96%) knew their HIV statuses. During this period, 1,356 HIV-positive women delivered in these facilities—871 (64%) received ART and 485 (36%) received ARV prophylaxis—and 1,330 infants received ARV prophylaxis. Most (98%) HIV positive women said they preferred exclusive breastfeeding for their infants.

Postnatal Care

A total of 498 exposed infants were tested with DNA polymerase chain reaction during FY13; 19(4%) tested HIV positive. A total of 714 babies who were exposed to HIV were enrolled for follow-up during this period. 749 Were initiated on cotrimoxazole prophylaxis; this figures includes babies enrolled from other health facilities. The annual figures show that 916 exposed infants were tested, of which 42 (4%) tested HIV positive. Of the 822 babies tested during the annual period, 577 (70%) were tested within 2 months of birth.

HIV & FP Integration

During the reporting quarter, 35 HIV-positive women enrolled in postnatal care. Of the 35 referred women, 19 (54%) were counseled and accepted family planning. During FY13, 583 HIV-positive women enrolled in postnatal care services. Of the 648 referred women, 295 (45%) were counseled and enrolled for family planning.

Additional Accomplishments and Highlights

- Most of the mothers (96%) who delivered in the faith-based hospitals had known HIV statuses. Almost all mothers who came to deliver with unknown statuses were tested during labor or soon after delivery.
- IntraHealth participated in validating the eMTCT national strategy with regional teams.
- To help implement PMTCT guidelines within the district, Onandjokwe conducted two days of in-service training on guidelines and tools.

Challenges, Constraints, and Plans to Overcome Them

- Though facilities have improved tracking and retesting for mothers who initially test negative in their earlier trimesters, sites must further strengthen this activity.
- HIV counseling and testing are not available at the Odibo maternity ward during the weekends. To alleviate this problem, IntraHealth will train three nurses in rapid testing during the next quarter. In the meantime, we encourage Odibo management to develop an on-call roster for counselors to cover the weekends.
- The final assessment of the dual protection tool pilot could not materialize due to competing priorities at the MoHSS. This will be a priority activity during the next quarter.
- The phased rollout of the Option B+ has been delayed to the following quarters. This is due to the need for training health care workers on the consolidated HIV/AIDS guidelines (ART, PMTCT, HCT, and Key Populations). IntraHealth will continue to play an active role in the rollout of finalized guidelines which will see an increase in the CD4 threshold for initiating ART to 500 cells/ul, ART for all pregnant and lactating HIV positive women, ART for an HIV+ partner in a discordant couple, ART for all children less than 5 years.
- There have been delays in finalizing approvals for the prefab for Odibo maternity ward. Separate meetings were held with Odibo management, Ohangwena RMT, MoHSS Policy Planning and the USAID. This activity is dropped since there was no commitment that AMS would have the funds to procure the foundation required by USAID regulations. Time is not sufficient to extend this activity any longer and still complete it within the funding period for this award.

Plans for Next Quarter

- Follow up EmONC/LSS in Kavango and Erongo regions.
- Participate in the adaptation process for EmONC/LSS curriculum
- Conduct baseline assessment for MTM activities in Kavango which includes site assessments and Kavango RMT to send a letter of request to Permanent Secretary at the MOHSS to pilot the program
- Finalize the maternity waiting homes guidelines and designs with feedback from MoHSS
- Finalize report for the maternal and neonatal survey.

- Finalize protocols and service contracts with UNAM and Tulipohamba for the rapid assessment of staff attitudes that contribute to poor maternal and neonatal outcomes; submit for MoHSS and IntraHealth internal review board approval; and collect data for the rapid assessment.
- Finalize the report for the dual protection tool pilot.
- Anesthesia training for one medical officer from Nyangana for one month

Mother to Mother (M2M)

IntraHealth has been requested by MoHSS to develop a concept note for a mother to mother support group programme as part of the elimination of Mother to Child transmission (eMTCT) agenda. The main goal of the Mother to Mother support groups is to eliminate mother-to-child transmission of HIV by empowering HIV-positive mothers and mothers-to-be to make informed decisions and support one another about infant feeding practices, reproductive health and the health of their babies and family.

IntraHealth plans to support the MoHSS in piloting the program in one of the regions while building on the best practices of other countries. Lesson learned will guide the expansion of the program to other facilities and regions. The program will help address identified gaps in the current PMTCT program.

Two IntraHealth staff undertook a study tour to learn more from IntraHealth Ethiopia which has successfully implemented the same program. During the fourth quarter, the concept note and implementation plan have been updated based on the findings from Ethiopia. IntraHealth has involved Kavango RMT in developing the concept note and the implementation plan.

Accomplishments & Successes

- A study tour on mother to mother has been successfully undertaken and feedback given to the stakeholders (except the PMTCT TWG).
- A concept note and implementation plan for Namibia has so far been developed with input from Kavango RMT. The training curriculum has also been adjusted to suit the Namibian situation.
- IntraHealth has successfully involved the Kavango Regional Management Team members to set the stage for the mother to mother pilot program in that region. Plans are at an advanced stage to acquire a go ahead for the pilot.
- PMTCT program indicators have been identified to serve as baseline for program evaluation.

Challenges, constraints and plans to overcome them

- Feedback meeting with MoHSS PMTCT technical working group could not be held because of the resignation of the chairperson of the TWG. . IntraHealth will continue to liaise with the group to maintain communication channels about this program.

Plans for the next quarter

- Secure written permission from the office of the Permanent Secretary for the pilot.
- Collect baseline data to serve as yard stick for program evaluation.
- Conduct site assessment at identified facilities
- Ensure concept paper has full support from MoHSS RMT, USAID and other key stakeholders including PMTCT TWG

2.2. Program Area 2: Voluntary Medical Male Circumcision

IntraHealth works to improve access to high quality HIV prevention services, and strives to make men aware of, and have access to, voluntary medical male circumcision (VMMC) services as a component of comprehensive HIV prevention. The minimum package for voluntary medical male circumcision (VMMC) package has been implemented including screening and management of sexually transmitted infections (STIs), behavior change counseling (risk reduction), provider-initiated counseling and testing (PICT) and condom promotion and distribution.

During the first six months of FY13, IntraHealth supported all six facilities, of which LMS (Onandjokwe), and all four Catholic Health Services (Andara, Nyangana, Rehoboth and Oshikuku) were offering VMMC, the Anglican Medical Services (Odibo Health center) was not providing VMMC due to the lack of demand. The last six months, IH continued to support only LMS whilst providing Technical Assistance to the other five facilities. This is because nurses were all absorbed in the government system as part of transition process.

Accomplishments & Successes

During FY13 Q4 alone, 48 men were circumcised in Onandjokwe hospital. All (100%) were tested for HIV and were negative. LMS achieved only 53% of their quarterly target (30 procedures per month). In FY13 Q3 alone, 118 (130% of target achieved) men were circumcised at Onandjokwe hospital, of which 116 (97%) were tested for HIV. Out of the 188 men circumcised, two (2%) tested HIV positive and two (2%) came in with known HIV positive status.

By the end of FY13, 421 (201 in Onandjokwe hospital, 29 in Andara hospital, 140 in Nyangana, 30 in Rehoboth, 20 in Oshikuku, and 1 in Odibo) men were circumcised. Consistent with the minimum package described above, all clients were offered HIV test, of which 419 (99.5%) were tested for HIV and two came with known HIV positive status. Two (0.5%) tested HIV positive.

Since the inception of the program in 2010, 2,083 men have been circumcised in IntraHealth supported sites. Two moderate adverse events (bleeding) were reported by Oshikuku and Onandjokwe and the

patients were attended to immediately. Five IntraHealth-supported facilities are now trained in VMMC. IH provided on-site orientation for staff at Odibo Health center.

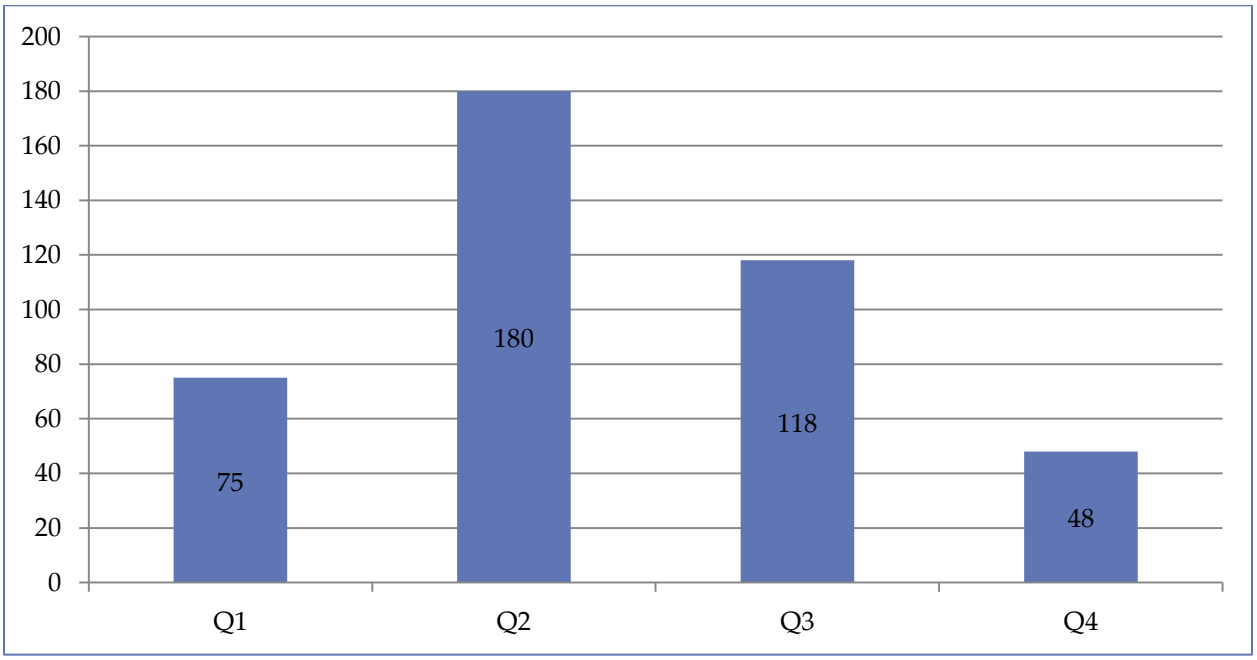


Figure 5: Number of MC performed

Other achievements during the reporting period include:

- In collaboration with MoHSS, I-TECH, and SHOPS, IntraHealth helped to develop the MC curriculum for private practitioners.
- Onandjokwe is referring clients from HIV counseling and testing (HCT) to voluntary medical male circumcision. During the last six months, 100 (48%) clients out of 166 men circumcised were referred from HCT
- All IntraHealth-supported sites receive MC kits from IntraHealth to improve MC services.
- The transferred MC trained nurse from Nyangana to Rehoboth is currently performing MC at his new facility (Rehoboth).
- IntraHealth participated to the demand creation international conference organized by Bill Clinton Foundation in Lusaka-Zambia during the third quarter. .
- The transfer of an MC Nurse from Hardap to Onandjokwe hospital has improved the MC uptake from 25 in Q2 to 118 in Q3.
- IntraHealth in collaboration with I-TECH conducted QA visits to Kavango, Otjozonjupa regions , Northwest facilities and Omaruru hospital

Challenges, Constraints and Plans to Overcome Them

- OGAC has suspended spending on MC activities for Namibia. This has negatively affected MC.
- The only MC Nurse at Onandjokwe hospital has been transferred to Oshakati, which has hampered Onandjokwe's MC services during the second quarter.
- The onsite MC orientation at Rehoboth could not materialize due to yellow light on MC activities which resulted in halting all MC activities by USAID.
- Since the yellow light (suspension) on MC spending was lifted by OGAC, PEPFAR will support two regions in the scaling up of MC in Namibia. MChip, new USAID funded program has taken over the MC program

2.3. Program Area 3: Post Exposure Prophylaxis (PEP)

According to Namibia's national guidelines, post exposure prophylaxis (PEP) must be provided within 72 hours following occupational, non-occupational or sexual exposure. IntraHealth continues to work towards strengthening the implementation of PEP guidelines, with a focus on data collection and reporting systems, while supporting training and skills updates, in order to improve awareness and eliminate missed opportunities for PEP within Namibian health facilities.

Accomplishments & Successes

During FY13 Q4 alone, 16 clients, from Onandjokwe hospital, benefited from PEP of which 7 were occupational, 5 rape cases and 4 non-occupational exposures. Ten (62.5%) returned within 3 days and 7 (44%) returned within 6 weeks. By the end of FY13, 78 clients were provided with PEP as follow: 24 due to occupational exposure, 35 rape survivors, and 19 from non-occupational exposure. All PEP recipients initially tested HIV negative.

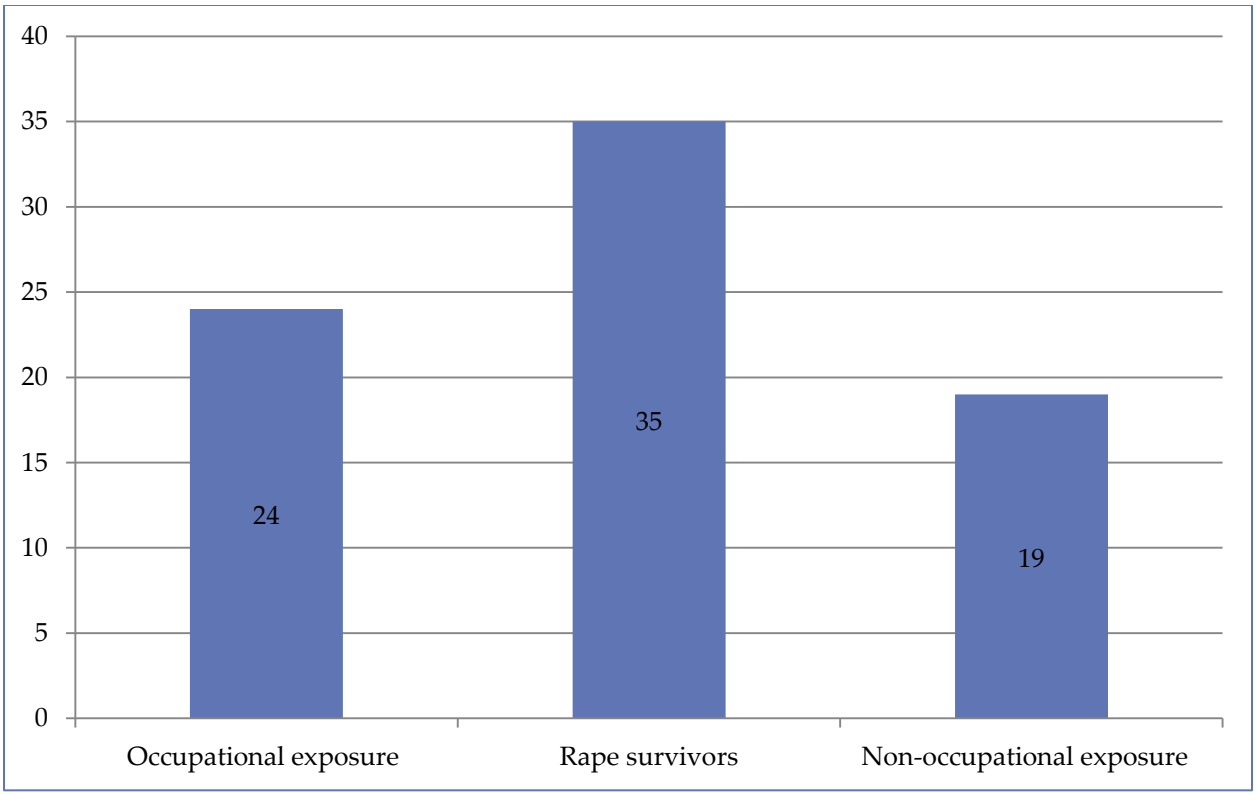


Figure 6: Number of PEP provided

Other achievements during the reporting period

- Out of the 12 rape cases in CHS during Q1, four were followed up at four weeks. Two completed the 28 days of ARV prophylaxis and tested negative at six weeks.
- By the end During FY13, 19 (24%) returned at six weeks and were all HIV negative, 4 clients returned at 3 months for LMS and were all negative.
- All IntraHealth-supported facilities are provided with PEP registers and are using them.
- PEP registers in all CHS facilities are kept at the HAART center where patients are referred to for HCT and follow up. There is need for better collaboration between the Matron who keeps her own register for occupational cases and the Infection Control Officer so that all PEP cases are captured.
- The low number of occupational PEP cases reported is attributable to injection safety and waste management held during in-service training and availability of PEP management protocols and well completed PEP registers.

Challenges, Constraints and Plans to Overcome Them

- Some clients do not report within expected period such as six weeks, 3 months. Counselors and community mobilizer will continue to provide awareness and educating the community about the need to report early to the health facility.

2.4. Program Area 4: Sexual and Other Behavioral Risk Prevention

Technical Assistance to Society for Family Health

IntraHealth continued to provide technical assistance to the Society for Family Health, particularly the organization's programs for the most at-risk populations, now known as key populations (KPs), which ensure that clients are linked to health services. During the year FY13 under review, IntraHealth provided technical assistance to:

- Conduct a sensitization campaign for health workers and hospital management teams in the 10 out of 14 regions where the program is running. The sensitization covered several topics related to key populations, namely an overview of those populations, STIs, and psychosocial and legal issues. The purpose of the campaign was to improve the quality of care provided to key populations in health care settings.

- Ensured that more people throughout the Erongo, Khomas, Karas, Ohangwena, Omusati, Oshana, Zambezi, Grootfontein & Kavango regions will have access to the care they need by training health workers there on the needs of most at-risk populations—namely, sex workers and men who have sex with men. Many health workers refuse to treat or refer these clients, which leads to rampant HIV infection. What started as an attempt to sensitize health workers at some FBOs has led to our work with the Society for Family Health, a national organization.

- Strengthen the referral between programs for key populations and the health facilities. We discussed the relevant referral tools, including referral boxes to facilitate bi-directional referrals. These were placed in all health centers in the program sites.

- Peer educators will now be assigned to clinics and health facilities in their regions for purposes of meeting with other sex workers and MSM as sensitized nurses and doctors encourage the identified MSM to join Peer Education groups facilitated in the regions

- More training for new recruits were carried out in Kavango, Oshakati, Khomas, Caprivi now renamed Zambezi and Erongo regions

- More sensitization sessions were successfully completed in the rest of the regions where the key population's program is running

- 'Moonlight' HCT, which will make HIV counseling and testing available after normal working hours up to after midnight and on weekends commenced well as a pilot in the Khomas and Erongo regions and lessons learnt there will influence strategizing for scale up in other regions.

Challenges, Constraints, and Plans to Overcome Them

- Many health workers are unaware of programs for key populations. And some key populations, such as MSM and sex workers, are criminalized. These remain major challenges. IntraHealth will continue to conduct awareness sessions in the respective regions.
- The National guidelines for management of STI's are still to be updated to included algorithms for the management of STIs in MSM as recommended by the World Health Organization. IntraHealth will continue advocating for the revision of the guidelines to incorporate KPs.
- The plans are on hold to train and certify MSM and sex workers as HCT counselors and HIV RT.
- Partners continued to provide mobile HCT services and in health facilities where clients will be referred for further clinical care.

Plans for Next Quarter

- TA to SFH will continue as per requests from them as work still remains with sensitization sessions in the rest of the regions where the key population's program is running.
- Training and sensitization of more health workers to the needs of MSM and sex workers required to reach the saturation point to make a change in delivery of sensitive services for the KPs.

2.5. Program area 5: HIV Counseling and testing

IntraHealth continued to support Counselling and Testing programs at the six Faith Based facilities namely: Andara, Nyangana, Odibo, Onandjokwe, Oshikuku, and Rehoboth. The priority during this financial year was to support facilities and regional managers to expand HCT services using mixed models. IntraHealth supported trainings to capacitate more staff on HCT and Rapid testing techniques. This was necessitated mainly by the need for scaling up of Provider Initiated Testing and Counselling (PITC).

With support from IntraHealth, Andara and Nyangana hospitals in Kavango region have rolled out PITC at OPD and wards in line with the MoHSS 2012 HCT guidelines. The two facilities were supported to identify space, equipment and staff, while furniture was purchased for Nyangana to facilitate the roll out.

Additionally, RMT staff was supported to take over HCT quality assurance using the Performance Improvement Approach (PIA). Staffs were trained on PIA while technical support was provided to improve MoHSS support visits using the IntraHealth performance support tools.

The position of the HCT TA was successful filled in the last quarter. Meetings were successfully held with MoHSS national office staff and other stakeholders to prepare for phasing out IntraHealth M&E tools to use those of the MoHSS. This transition took effect by end September 2013.

During the year under review, a total of 22,060 were tested and received their results. Of the total clients tested, 20,187 (92%) were first time testers, 2,685 (12%) tested as couples (Figure 7) while a total of 1,815 (8%) tested positive (figure 7). There has been a marked decline in the total number of individuals who tested as couples this year compared to last year.

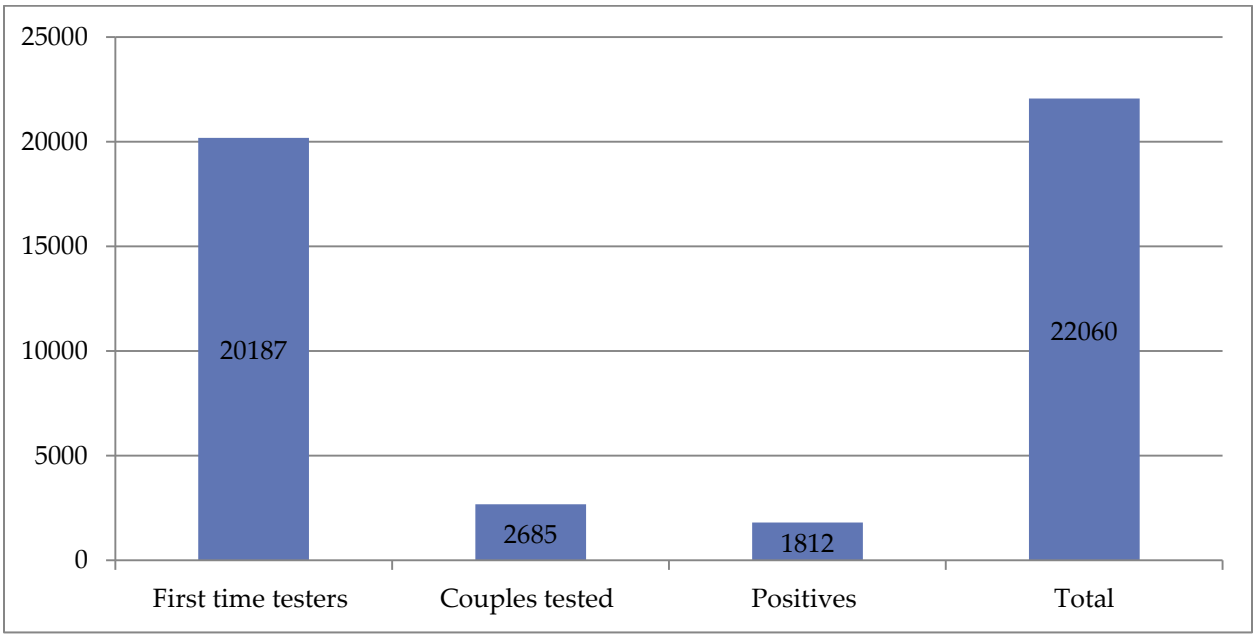


Figure 7: Clients who received HCT October 2012 to September 2013.

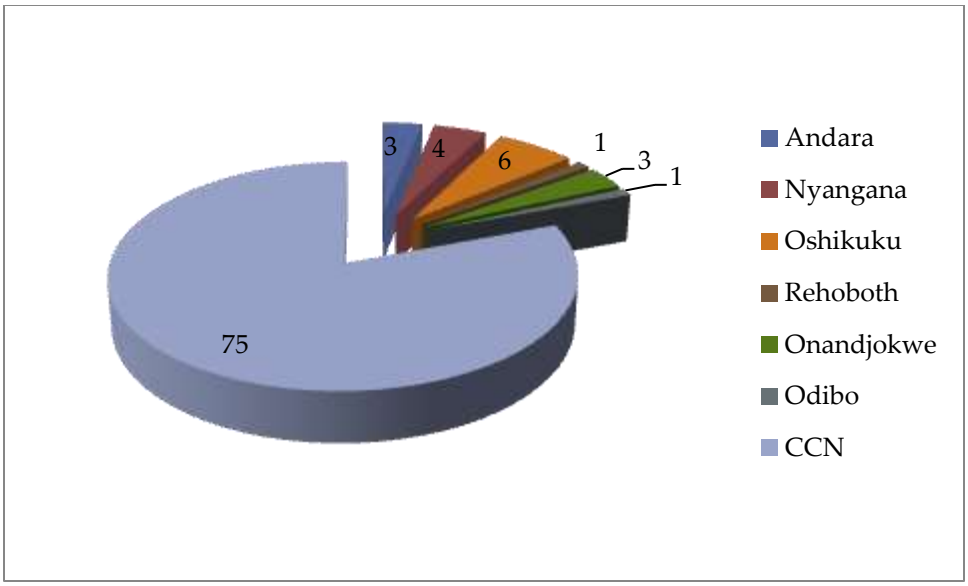


Figure 8: Percentage of Individuals counseled as couples by site during October 1, 2012- September 30, 2013

Accomplishments & Successes

- Five (5) trainings were conducted on HCT and RT
- PITC was successfully implemented at Andara and Nyangana hospitals in the Kavango region and St Mary's Rehoboth in the Hardap region
- The IntraHealth M&E tools have been successfully phased out.
- Integration of CBD and CCN HCT centres has been successfully effected.
- Bi-Directional Referral system & PIA training was given to the now combined staffof LL/CL & CCN.
- IntraHealth continued providing technical support to ELCAP's Rehoboth and Mariental New Start Centers. HCT quality assurance assisstance in accordance with the Standard Operating Procedures for HIV rapid testing were reinforced and strengthened as required and vists with the RMT in Hardap in facilitation of the transition to MoHSS was done.

Challenges, Constraints, and Plans to Overcome Them

- Space and inadequate number of trained staff remain a challenge for PITC implementation at Andara and Nyangana. IntraHealth will liaise with I-TECH to train more staff on HCT and Rapid Testing.
- The handover of mobile vans to the MoHSS has yet been delayed. IntraHealth continues to liaise with stakeholders to accomplish this task in October 2013 and support mixed model approach.

Plans for Next Quarter

- Conduct training needs assessment for the FBOs
- Offer TA to the remaining FBO facilities and MoHSS at large to scale up PITC.
- Official handover of HCT mobile units to MoHSS.
- Provide TA for mobile HCT
- Continue with management of HCT skills transfer with the transitioning of HCT QA to the MoHSS RMT, Hospital Management & QA/PHC officers

2.6. Program Area 6: Care – Adults

To reduce morbidity and mortality among people living with HIV, IntraHealth is helping 28 service outlets to provide the minimum package of basic health care. The outlets provide the following elements of the clinical care: prevention and treatment of opportunistic infections; tuberculosis (TB) screening; Isoniazid (INH) prophylaxis; pain and symptom management; nutritional assessment; food promotion; hygiene and food demonstration through Kitchen Corners; and micronutrient supplementation in the form of multivitamins, iron, and folic acid. The facilities also provide psychosocial support (including spiritual counseling) and links to with other palliative care providers, such as the Red Cross and other community-based organizations.

IntraHealth has rolled out the integrated management of adolescent and adult illness (IMAI). Local partners are now implementing it.

During the last six months, IH supported LMS in five service outlets (Onandjokwe hospital, Okankolo HC, Onayena HC, Onyaanya HC and Omutele clinic) in Onandjokwe district to provide the minimum package of basic care services (prior to the last six months IH supported activities for all partners)The outlets continue to provide the following elements of clinical care: prevention and treatment of opportunistic infections; tuberculosis (TB) screening; Isoniazid (INH) prophylaxis; pain and symptom management; nutritional assessment; food promotion; hygiene and micronutrient supplementation in the form of multivitamins, iron, and folic acid. The other five FBOs were provided with technical assistance only.

Accomplishments & Successes

- By the end of Q2 FY13, IntraHealth provided at least one HIV service to 33,536 eligible adults for all partners. This represents 87% of the 38,487 adults and children who received at least one service from an IntraHealth-supported site. A total of 26,031 HIV-positive adults are receiving co-trimoxazole prophylaxis, representing 88% of 29,614 adults and children on co-trimoxazole prophylaxis.
- By the end of FY13, at Onandjokwe hospital alone (since nurses at AMS and CHS were already absorbed and no longer report to IH), IntraHealth provided at least one HIV service to 15,134 adults representing 86% of the 17,619 adults and children who received at least one service

from LMS. A total of 13,143 HIV positive adults are receiving CTX representing 87% of 15 ,149 of adults and children on co-trimoxazole prophylaxis.

Other Accomplishments & Successes

- By end of Q2, Nutritional assessment counseling and support has begun at two sites (Onandjokwe and Odibo), allowing mothers and other patients to be screened, treated, and referred early and for follow-up. These sites provide clients with basic knowledge on nutrition using low-cost, locally available, nutritional foods. By the end of the quarter, 63 adults were identified and supplied with therapeutic and supplementary food (4 in Odibo and 59 in Onandjokwe).
- By the end of FY13, 86 clients were identified and supplied with therapeutic and supplementary food. Five facilities (Andara, Rehoboth, Nyangana, Odibo, and Onandjokwe) are calculating clients' body mass indexes. Only one facility in Oshikuku does not calculate body mass index.
- Two facilities (Nyangana and Odibo) have shown improved performance after PI approach trainings in the Q4 of FY12.
- In Nyangana, out of 220 expected clients per month, only 40 (18%) were tested for HIV. After interventions (including a stakeholders meeting and providing fuel for outreach and outreach campaigns), the number of tests increased to 407 (185%) in October and 137 (62%) in November.
- In the Odibo health center, 30% of eligible pregnant women could not receive AZT because health workers lacked the necessary information and knowledge. After in-service training, there was an increase—80% of eligible pregnant women received AZT in October and 100% in December 2012.
- IntraHealth finalized the pilot for a bi-directional referral system. Though there are some challenges (including stock outs, the cost of printing tools, and a lack of implementation by some facilities) the system showed positive results for the facilities that implemented it correctly.
- The report of the final evaluation of the bi-directional referral system is finalized and presented to the Division of Special Programs (DSP) and the senior management of the MoHSS.
- IntraHealth in collaboration with the MoHSS conducted three trainings in Hardap and Karas regions as part of B-D referral system roll out program. A total of 67 health workers were trained; 21 in Karas region including 7 RN, 3 EN, 9 CC and 2 Data clerk and 46 in Hardap region including 1 doctor, 1 CHPA (Chief Health Program Administrator), 1 SCHPA (Senior Chief Health Program Administrator), 3 PRN, 22 RN, 4 EN, 12 CC and 2 Data Clerks.
- IntraHealth conducted training on PIA in Kavango region as per CMO request to improve performance and improve the existing tool to more performance based approach.

Challenges, Constraints, and Plans to Overcome Them

- The shortage of staff in Onandjokwe does not allow weekly KC activities, IH will continue, in collaboration with local management, to encourage an increase of number of sessions at once per week.

Plans for Next Quarter

- To conduct a stakeholders' meeting for feedback and B-D referral tools revision
- Continue to support Onandjokwe to increase the number of KC sessions.

2.7. Program Area 7: Treatment: ARV Services – Adults

IntraHealth is supporting an integrated and comprehensive HIV and AIDS care and treatment program for adults in six mission facilities, comprised of five district hospitals and one health center. This program extends to their satellite facilities through outreach services and IMAI. During the reporting period, IntraHealth helped 28 outlets to provide HIV and AIDS clinical care.

Accomplishments & Successes

By the end of Q2, 20,947 adults living with HIV were receiving antiretroviral therapy (ART) at IntraHealth supported sites. During Q2 FY13, 1,184 adults living with HIV initiated ART.

By the end of Q2, out of 327 adult patients started on ART during Q2 FY12, 85.6% were still alive and on treatment. This relatively good trend of retention of ART patients is a result of significant and continued efforts in adherence counseling, support group activities and active defaulter tracing. Note that Rehoboth had only one patient started on ART who died later. IntraHealth will follow up with Rehoboth to establish the reasons for the low retention (see Figure 7).

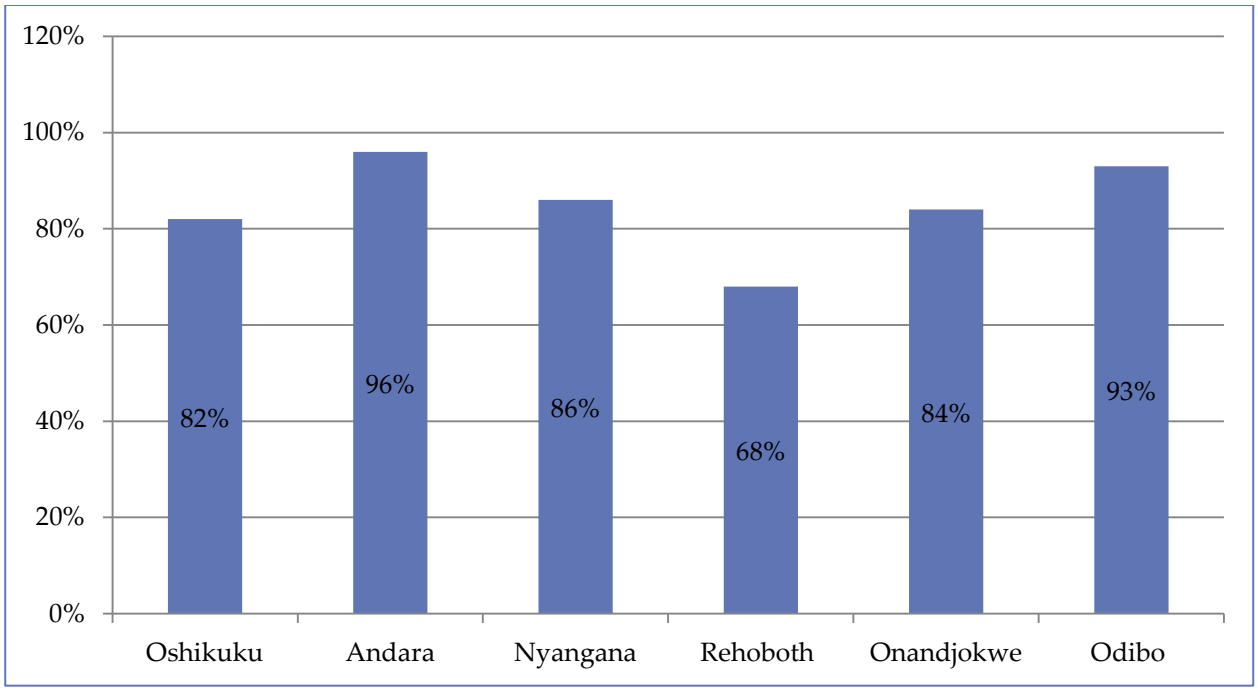


Figure 9: Retention in Care of ART Patients by Health Facility, January-March 2013

After transitioning clinical staff of five mission facilities over to the MoHSS in FY13 Q3, IntraHealth is now supporting an integrated and comprehensive HIV and AIDS care and treatment program for adults in Onandjokwe hospital only. This program extends to its satellite facilities through outreach services and IMAI. During the reporting period, IntraHealth supported five outlets providing HIV and AIDS clinical care in Ondanjokwe district. However, IntraHealth will continue providing technical support to all FBOs through their respective RMTs in the form of mentorship for supportive supervision using the performance improvement approaches (PIA).

By the end of FY13, 8,742 adults were receiving ART at Onandjokwe hospital and 1,364 initiated ART. By the end of FY13, out of 283 adults started on treatment a year ago, 228 (81%) are still alive and on treatment. The remaining 19% include those who died and lost to follow-up.

Other Accomplishments & Successes

- Joint supportive supervision visits with RMTs conducted in all IH supported sites as part of transition process.
- Odibo site with the help of the clinical mentor become part of 2nd line review panel at Engela district hospital to look at all cases on second line therapy.
- Odibo established a third outreach point at Ndapona JP School, started February 2013.

Challenges, Constraints, and Plans to Overcome Them

- The number of patients receiving services at ART clinics has outstripped the available space in most of the facilities. Increases in the outreach activities are also expected to decongest the main facilities.
- All IntraHealth-supported sites are conducting tracing of ART patient defaulters; however, the availability and cost of transport remain major challenges, especially in Onandjokwe. To bridge the gap, Onandjokwe is still conducting outreach services in 8 facilities of which 2 of them are health centers and six clinics.

Plans for Next Quarter

- Continue supporting care and treatment to all HIV-positive individuals at Onandjokwe hospital until nurses are absorbed by MoHSS.

2.8. Program Area 8: Care – Children

IntraHealth is helping to provide care to children who are infected—or suspected to be infected—with HIV. We work to provide the following elements of clinical care: prevention and treatment of OIs; TB screening; Isoniazid (INH) prophylaxis; pain and symptom management, including the use of opioids; nutritional assessment and food promotion; and micronutrient supplementation in the form of multivitamins, iron, and folic acid. Patients also receive psychosocial support (including spiritual counseling) and are linked with other palliative care providers, such as the Red Cross and other community-based organizations. IntraHealth has rolled out integrated management of childhood illness (IMCI). Our local partners are now implementing it.

During the last six months, IH supported LMS in five service outlets (Onandjokwe hospital, Okankolo HC, Onayena HC, Onyaanya HC and Omutele clinic) in Onandjokwe district to provide the minimum package of basic care services. The outlets continue to provide the following elements of clinical care: prevention and treatment of opportunistic infections; tuberculosis (TB) screening; Isoniazid (INH) prophylaxis; pain and symptom management; nutritional assessment; food promotion; hygiene and micronutrient supplementation in the form of multivitamins, iron, and folic acid. The other five FBOs were provided with technical assistance only.

Accomplishments & Successes

By the end of FY13 Q2, 4,951 children under the age of 18 were provided with at least one HIV clinical care. This represents 13 % of the 38,487 individuals currently receiving care, including adults. A total of 3,583 HIV-positive children were provided with co-trimoxazole prophylaxis (CPT). This represents 12 % of 19,614 adults and children receiving co-trimoxazole prophylaxis.

By the end of FY13, in Onandjokwe alone (LMS), 2,485 children under the age of 18 were provided with at least one HIV clinical care. This represents 14% of the 17,619 individuals receiving care, including Adults. In addition to this 2,006 HIV-positive were provided with co-trimoxazole prophylaxis representing 13% of 15, 146 adults and children receiving co-trimoxazole prophylaxis.

In all IntraHealth-supported sites, pediatric care also includes the diagnosis and treatment of malaria, and referral for routine and timely immunization programs and campaigns. Routine provision of CPT at 6 weeks of age is given, according to the national guidelines for HIV exposed infants. For HIV+ children, CPT is continued, as well as IPT, TB screening, nutritional assessment, and pain management. All IntraHealth supported facilities offer diagnosis and management for OIs and co-morbidities, including diarrhea and pneumonia. As with adults, all children in care are screened routinely for TB in every follow up visit, and referrals are made for suspected cases to the TB clinic for registration, prescription and follow up. Likewise, HIV testing is conducted for all children diagnosed with TB. Infants initially testing HIV- but remaining at risk due to ongoing exposure from breastfeeding are also retested.

Additional Highlights during Q4 FY13

- Three staff members from Odibo (HAART nurse and two counselors) participated in child counseling and disclosure training.
- During FY13 Q4 alone, 75 children were provided with counseling and disclosure process, using the MoHSS and I-TECH tool. By the end of FY13, a total of 171 children were provided with counseling and disclosure process, using the MoHSS and I-TECH tool.
- The Rehoboth Garden of Hope has been successful. It is operated by both expert patients who are on treatment and volunteer to support the program and PHDP patients who have been given plots to start their own gardens. They have in season watermelons, onions and carrots and pumpkins and their chickens produce seven to eight dozens of eggs a day which are then sold to the hospital.
- Four staff members from Onandjokwe (HAART nurse and two counselors) were trained in child counseling and disclosure training.
- Kitchen corner activities conducted in Onandjokwe hospital; 4 sessions were conducted with a total of 70 children and 50 parents/caregivers attending these activities.

Challenges, Constraints, and Plans to Overcome Them

- The shortage of staff in Onandjokwe does not allow weekly KC activities, IH will continue, in collaboration with local management, to encourage an increase of number of sessions at once per week.

Plans for Next Quarter

- Continue to encourage local management to increase the number of KC sessions in Onandjokwe hospital.

2.9. Program Area 9: Treatment: ARV Services – Children

IntraHealth is supporting a program for integrated and comprehensive HIV and AIDS care and treatment for children in all six mission facilities, comprised of five district hospitals and one health center. This program extends to their satellite facilities through outreach services and IMAI. During the reporting period, IntraHealth helped 28 outlets to provide HIV and AIDS clinical care and ARV services for children.

Accomplishments & Successes

Overall, 2,863 children on HIV care are currently receiving antiretroviral therapy; this represents 12% of all patients. In Q2 FY13, IntraHealth supported sites enrolled 54 children into ART. This represents 8.6% of adults and children enrolled into ART during the reporting period. *Figure 5* (see below) shows the percentage of children out of the total number of patients on ART by facility.
Partner facilities have been continually sensitized to active screening and earlier identification and recruitment of HIV-exposed children in order to expedite entry into care and treatment. Early infant diagnosis and the recommended Namibian ART approach of commencing ART earlier for children have been rolled out in all IntraHealth supported sites. This change in treatment protocol is expected to have a significant increase in the ART initiation among children younger than 24 months of age. All identified HIV exposed infants will be provided with ARVs and co-trimoxazole prophylaxis as per the national guidelines.

By the end of FY13, 1, 038 children were receiving ART at Onandjokwe hospital and 103 initiated ART.

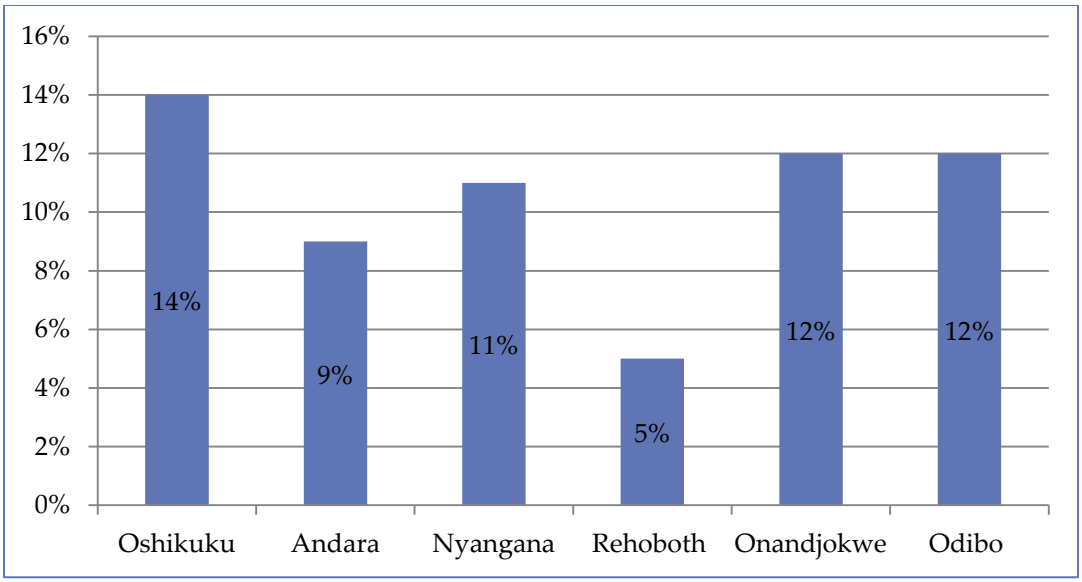


Figure 10: Percentage of ART Patients that are Children by Health Facility, January-March 2013

Challenges, Constraints, and Plans to Overcome Them

- Staff shortages in most facilities in Onandjokwe limit their ability to trace exposed infants at home. IntraHealth will continue to encourage partners to leverage the community based organizations such as CAA and Project Hope, to assist with follow up and tracing of defaulters.
- The majority of the ART nurses are not trained in the new guidelines; IntraHealth will continue to liaise with NHTC, RHTC and I-TECH to link to assist partners to develop and forward their training needs through relevant channels.

Plans for Next Quarter

- Continue strengthening defaulter tracing using SMS.

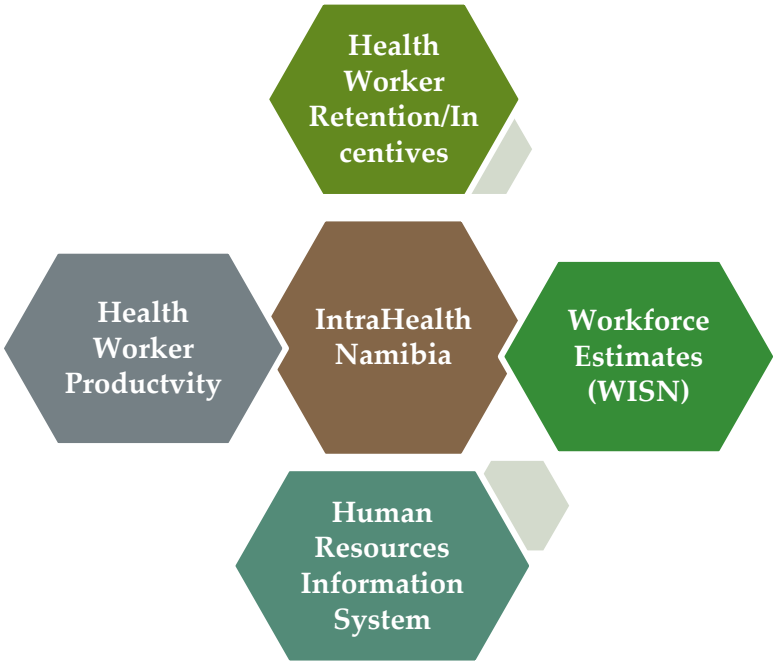
2.10. Program Area 10: Health Systems Strengthening (HSS)

2.10.1 Human Resources for Health

The ability of IntraHealth's Namibian partners to operate as vibrant, autonomous organizations that contribute to the national HIV response is a key indicator of project success. A critical step towards achieving this indicator is to empower our local partners to access funding directly through a variety of sources, including their own government, private and corporate sponsors, and international donors and foundations.

IntraHealth is now helping our FBOs to transition their staff to non-US Government funding and to improve their organizational sustainability and capacity. During the FY13, all the USG-funded nurses (except LMS), doctors, pharmacists and pharmacy assistants have been successfully absorbed. We are monitoring the MoHSS' absorption of community counselors and data clerks who require new job descriptions to be approved by the OPM before absorption since these are new cadres in the GRN staff establishment.

IntraHealth is currently supporting and providing technical assistance to the MoHSS on the following human resources for health areas:



2.10.1.1. Health Worker Retention/Incentives

The MoHSS conducted a study in 2010 to identify incentives that attract and retain health professionals. Health worker attraction and retention represents a major challenge to the delivery of high-quality health services, particularly for those who live in hard-to-reach areas —which is where approximately half of Namibia's population lives.

The MoHSS asked for IntraHealth's technical assistance in reviewing their draft report, including providing comments to improve the quality of the report and the Ministry's ability to use the recommendations from the report. As a result of IntraHealth's advice on ways to improve the report, the Permanent Secretary asked IntraHealth to conduct additional analyzes and finalize the incentive and retention study so that appropriate recommendations can be given to the Office of the Prime Minister. This will help design appropriate attraction and retention strategies for the MoHSS.

Since there are numerous recommendations, IntraHealth recommended to the MoHSS that they apply a rapid discrete choice experiment (DCE) using the Capacity*Plus* Rapid Retention Survey Toolkit, which helps determine the right incentives for attracting and retaining health professionals in hard-to-reach or remote areas. This strategy would include building the capacity of the MoHSS and UNAM to conduct future DCEs after the initial training.

Accomplishments & Successes

Regular meetings were conducted with the MoHSS to review the draft report on the study conducted by the MoHSS on staff retention and incentive in hard to reach areas of Namibia.

An agreement was reached with UNAM (MRC) to support finalization the report. UNAM (MRC) completed the analysis and finalized the draft report. The report was presented to the MoHSS' Human Resources Development Division and the Restructuring Committee.

Intrahealth is preparing for the training, capacity building and roll-out of the DCE by contracting technical assistance from experts and also to build capacity by training some of our local staff and partners to be able to do the DCE on their own.

Challenges, Constraints, and Plans to Overcome

Implementation of activities depends mostly on decisions from the Ministry of Health and Social Services. The suggestion to implement Discrete Choice Experiment to help make decisions regarding the right mix of incentives for Ministry is dependent on the MoHSS' Senior Management Committee.
To date, IntraHealth is still waiting for a date from the MoHSS to present our recommendation to use the DCE to the Senior Management Committee.

Plans for Next Quarter

Our plans for the next quarter include making a formal presentation of the results of the study, gaining final approval of the Incentive and Retention Report by the MoHSS' Senior Management Committee, developing a dissemination plan for the report and receiving approval to build capacity and to conduct a Discrete Choice Experiment based on the recommendations from the study.

2.10.1.2 Workforce Estimates

National WISN

IntraHealth has helped the MoHSS to revise the staff establishment and staffing norms in order to meet workload requirements. IntraHealth applied the WHO WISN (Workforce Indicators of Staffing Norms) method as a means of measuring the adequacy of staffing levels and workload distribution in facilities by identifying the ideal numbers and types of health workers needed. Intrahealth has applied the WISN to the following cadres: Nurses, Doctors, Pharmacists and Pharmacy Assistants. Building upon the success of the WISN pilot in the Kavango region, the MoHSS's restructuring committee asked IntraHealth and its Capacity*Plus* project to support the national roll-out of WISN for all thirteen regions. We conducted training for clinical and management experts from all thirteen regions during quarter one.

The WISN software tool was developed to enter data manually for each health facility by cadre. However, to conduct WISN nationally, the information technology staff at IntraHealth developed a code that would allow the data to be uploaded directly from national databases into the WISN software, thus improving the data quality and data entry time. The data for the national estimates were coming from the health information system database; the electronic patient management system (ePMS) database (HIV/AIDS care and treatment); the PMIS database (pharmaceutical); and from the regional management teams for the human resources data, since those data are between two different national databases and there is not a current HR database at this time. In order to ensure that the national databases were accurate, a team visited four regions (Erongo, Omaheke, Omusati, and Karas) in December 2012 to validate the data against primary data sources at a sample of health facilities.

During Quarter 2 the IntraHealth team finalized the national activity standards for medical officers, nurses, pharmacists and pharmacy assistants for intermediate and district hospitals, health centers and clinics. Service statistics from the national databases were aligned to activity standards and uploaded into the WISN software. Where data did not exist for important activities, such as number of major surgeries, with the support from Dr. Forster, primary data from the theatre records was collected. All thirteen regions supplied HR data for the time period from April 1, 2011 until March 31, 2012 (the GRN fiscal year); the time period used for the national WISN. After uploading the data and running a sample of reports, the IntraHealth staff identified several software issues, which were communicated to WHO. Subsequent adjustments were made to ensure accurate results. Several meetings were held with Pharmacy experts to finalize the WISN standards for pharmacists and pharmacy assistants as their standards needed some additional work. At the end of quarter two, all data were uploaded and preliminary analysis of data was conducted.

A preliminary presentation of the results and policy recommendations was made by the WISN technical team to the MoHSS National Management Development Forum on February 7, 2013.

Data verification on various outliers

In quarter four, some of the WISN data was again validated due to anomalies that were identified in the National WISN outcomes. Data was verified on various outliers i.e. those facilities who registered a

WISN ratio of 0.33. These facilities included the following clinics: Robert Mugabe-, Okuryangava -, Otjomuise -, Olutsiidi-, Ongulumbashe- and Oluteyeni Clinics.

Another outlier was noticed in terms of in-patient days versus admissions. All the facilities were verified and it was noticed that the only outlier was Oshakati Hospital where admissions registered were far below the midnight census conducted. The data discrepancies were taken up with the facility.

Windhoek Central Hospital and Katutura Intermediate Hospital

The MoHSS's restructuring committee/Permanent Secretary asked IntraHealth and its Capacity*Plus* project to use the WISN methodology to estimate workload requirements for medical officers and nurses in Internal Medicine and OB/GYN Units. This exercise also accounted for the additional time requirements for training medical and nursing students and medical interns at Windhoek Central Hospitals and Katutura Intermediate Hospital. Following a similar methodology above for the national WISN estimates, workload estimates were finalized with support from technical experts from the two hospitals and presented to the MoHSS's Restructuring Committee during quarter two. The estimates indicated that medical officers and nurses are generally understaffed with medical officers having far fewer staff than required compared to nurses. Katutura Intermediate Hospital had less staff required using than WISN estimates compared to Windhoek Central Hospital.

Facility	MO Actual Internal Medicine	MO Required Internal Medicine	MO Actual OB/GYN	MO Required OB/GYN	Nurse Actual Internal Medicine	Nurse Required Internal Medicine	Nurse Actual OB/GYN	Nurse Required OB/GYN
WCH	5	9	7	20	60	50	90	97
KIH	11	45	7	29	89	113	96	115

Figure 11: WISN estimates for OB/GYN and Internal Medicine Medical Officers (MO) and Nurses compared to actual staffing and KIH and WCH Teaching Hospitals in Windhoek

Onamunama Clinic in Engela District

The regional director of the Ohangwena region wrote to the Permanent Secretary, Ministry of Health and Social Services (MoHSS) on behalf of the Onamunama (Hamukto waKapa) clinic in Engela district. The letter requested a revision of the clinic's staff establishment due to its high workload. In response to this, the MoHSS requested IntraHealth to apply the WISN (Workload Indicators of Staffing Need) methodology to estimate how many nurses this clinic would require based on actual workload. Findings and results of the WISN of the Onamunama (Hamukoto waKapa) were presented to the

MoHSS Restructuring Committee and the report indicated that the clinic requires six nurses to cope with its current workload. The clinic is currently staffed by only two nurses (one registered and one enrolled), leaving a gap of four nurses.

Dr. Riitta- Liisa Kolehmainen-Aitken, Dr. Grace Namaganda and Norbert Miijumba provided technical support in the application of the WISN tool during the pilot and national phases.

Accomplishments & Successes

- **Customization of the WISN Tool:**

The WISN tool was customized to the Namibian context and later used to make calculations of required staffing based on workload. The areas customized included:

- Geographical features like regions and districts,
- Staff types at each facility level,
- Available working time for the selected staff types,
- Salary levels for the staff types studied and
- Activity and allowance standards for the studied staff types.

The WISN technical taskforce determined the available working time taking into consideration the time lost due to authorized absences. These include annual, compassionate, maternity, and sick leaves and days spent on both long training and short trainings/workshops.

- WISN applied for all National Level Facilities: All Intermediate Hospitals/District Hospitals/Health Centre's/Clinics. The human resources data for all facilities were loaded into WISN.
- The service statistics from HIS, ePMS, PMIS were uploaded into WISN for every facility according to the service standards.
- IntraHealth wrote computer code to upload data directly from national databases into WISN software.
- Activities standards for Medical Officers, nurses, pharmacists, and pharmacy assistants were agreed upon by clinical and management experts from all thirteen regions in Namibia.
- Preliminary comparisons across facilities and regions made for different cadres.

National Level data validation in four regions (Erongo, Omaheke, Omusati and Karas:

For the national level WISN exercise, a joint technical team, MOHSS, and IntraHealth collected data and conducted a validation exercise from the primary data sources for data on staffing levels from facilities in Omusati, Erongo, Karas and Omaheke regions. Workload data was obtained from the HMIS, EPMS, PMIS, and HRIMS and validated against patient records in the studied health units. Data was for the

period of 1st April 2011 to 31st March 2012, the Namibian fiscal year. The data verification showed that there was little variance between data in the primary data sources and electronic databases. A total of 28 facilities were included in the National WISN validation exercise.

Level	Number
District Hospitals	7
Health Centers	6
Clinics	15
Total	**28**

- 7 District Hospitals: Swakopmund, Usakos, Outapi, Oshikuku, Keetmanshoop, Karasburg and Gobabis. Health: Centers: Karibib, Walvisbay, Mahenene, Okalongo, Noordoewer and Otjinene.
- 15 Clinics: Coastal, Hakhaseb, Mondesa, Ruacana, Onawa, Ongongo, Olutsiidi, Aussenkehr, Keetmanshoop, Koes, Tses, Omitara, Aminius, Epukiro and Epako.

Facility	Med Officer Gap	WISN Ratio	Nurse Gap	WISN Ratio	Pharm Gap	WISN Ratio	Pharm Assistant Gap	WISN Ratio
Intermed Hospital	-70	.31	-.1	.96	-23	.12	+1	1.16
District Hospital	-196	.36	+148	1.1	-189	.03	-99	.32
Health Center			-63.2	.85			-54	.11
Clinic			-210	.77			-136	.02
TOTAL	**-266**		**-125**		**-212**		**-288**	

Figure 12: National WISN results for doctors, nurses, and pharmacists by facility type

3. WISN Results Presented to MoHSS National Strategic Planning Committee, Restructuring Committee and other key partners

- WISN results from Kavango region, WCH, KIH, and Onamanama results and policy recommendations were presented to the MoHSS National Management Forum (7 February, 2013) with recommendations for how these data will support their restructuring efforts and staffing norms.
- A policy document on WISN was prepared and shared with the Restructuring Committee and USAID Washington (April 2013)
- Dr. McQuide represented IntraHealth at the May 31, 2013 USAID Meeting in Washington, DC on Namibian Transition Efforts and presented the National WISN results and other transition activities undertaken by the project.
- The National WISN results were presented during the MoHSS' 21 June 2013 Restructuring Committee. A decision was taken that these results should be presented in the upcoming Strategic Planning Retreat the following week.
- During the 1 July 2013 MoHSS Strategic Planning Retreat, attended by the Minister of Health, Deputy Minister of Health, Permanent Secretary and Deputy Permanent Secretary and directors from all regions, the national WISN results and policy recommendations on use of results were presented, including the findings from the WISN assessment of WCH/KSH ObGYN & Internal Medicine. The MoHSS executive team was very appreciative of the approach and findings to estimate workload for these critical health cadres. These results will be used to estimate workload requirements and identify facilities most in need of additional staff.
- As a result of a meeting on 12 July with MoHSS Deputy Permanent Secretary it was agreed that:
    - MoHSS would coauthor the development of the WISN peer reviewed article.
    - The Permanent Secretary agreed to have a delegation from the MoHSS attend the Global Health Workforce Alliance meeting in Brazil.
    - To extend the Restructuring Task Force into National Observatory; WISN institutionalization; Retention study: please let us discuss these at the next RTF meeting with the members.
    - Successfully arranged the delegation from the MoHSS to attend the GHWA Meeting in Brazil.

Other Accomplishments this quarter:

- At the request of the MoHSS Deputy Permanent Secretary IntraHealth was asked to run the WISN data so that the MoHSS could identify which facilities were operating under extreme workforce pressure. This will allow the Ministry to prioritize those facilities that need to have short-term staffing improvement. The IntraHealth COP made a presentation of these data to the Restructuring Task Force committee on 19 July.

- A draft WISN peer reviewed paper for the WHO/HR journal was finalized in collaboration with the Deputy PS and Director HRM. This paper was submitted for publication.
- The WISN activity standards and service statistics for WIC and Katatura were shared with the ABT HS2020 program which is doing feasibility study for the merger for Windhoek and Katatura Central. They indicated that these data were very helpful for their workforce estimates in the various scenarios for the potential merger of the two national hospitals.
- WISN data for specific health facilities was shared with UNFPA that was doing a work flow analysis of MCH and HIV services in a sample of health centers and clinics.
- Presented to USAID for the Health Extension Worker (HEW) meeting to assess staffing at facilities in the proximity of HEW.
- WISN data shared with the ABT HS2020 project to use WISN results to cost health workforce planning using the different policy scenarios described in the results.

Challenges, Constraints, and Plans to Overcome Them

1. There are several WISN software errors that were found after data was entered, e.g. the calculations were incorrect for standards that used hours per month or days per year. We communicated these errors to WHO and they made software changes. The WISN software is not open-source software so it is difficult to know how the calculations were made.
2. Although the IntraHealth information technology team established a way to upload data directly into the WISN software, it created some challenges for running the summary reports for the institutions. We did find a way to remedy the situation but it meant that we had to individually save every facility file after minimizing the manual procedure.
3. Although most data was verified there seem to be a need to identify outliers related to issues of uploading the data or wrong data entry at primary site for a specific facility.

Plans for Next Quarter

- A comprehensive report will be completed and shared with MoHSS for all WISN activities undertaken to date. Dissemination plans with MoHSS will be finalized.
- Develop plans with MoHSS to train team of experts to conduct WISN and actually complete WISN exercises for community counselors and data clerks.
- Finalize any recommendations from peer reviewed paper on WISN for the WHO HRH Journal.
- Finalize the planning to Global Health Workforce Alliance meeting in Brazil in November. A Namibian team has been asked to present human resources for health (HRH)-related strategies in a side event.
- Finalize the National WISN report
- Finalize a plenary meeting to complete the country commitment to be presented at the GHWA Meeting in Brazil

2.10.1.3. Improved usage of HRIS data

IntraHealth has been a crucial partner to our FBO's in ensuring they have access to timely, accurate, and reliable HRH data. The HRIS system was developed by the IntraHealth HRIS team and has been rolled out to LMS and AMS. However it has been found that after the HRIS systems have been implemented and the data is accurate and available for use, the FBO's and in particular LMS has not shown an improved usage of the system.

IntraHealth has provided technical assistance to make LMS aware of the data available in the HRIS system and how they could be using this data to make better management decisions. Further, additional support was provided to the HR team (4 employees) at LMS to assist them in the development of a Human Resources Management Information Pack. This could be presented to the management team on a monthly or quarterly basis. This template presents the HR information such that the management has a bird's-eye-view of the developments and status of the HR work.

The HR information reported on in the management pack are all obtained from the HRIS system and presented in a PowerPoint format of about 8 slides. The final presentation was developed in collaboration with the HR team and presented to the management. The management (6 employees) received the report favorably and has tasked the HR department to present them with an updated version including all information for the last quarter.

Accomplishments & Successes

A meeting was conducted with the HR Department to finalize the PowerPoint template and populate some of the data available to demonstrate to the management.

The template was presented at the LMS Management meeting on 25 September and the report was very well received. An agreement was reached with the HR department to populate the complete data into the template and present this to the management committee.

Intrahealth is preparing for the training, capacity building and roll-out of a similar template to AMS once their HRIS system is fully functional.

Challenges, Constraints, and Plans to Overcome

It is always a challenge to have the management log on to any system, including HRIS. Therefore the aim was to present the information in the HRIS system to the management in such a way that it would be easier for them to track HR progress in their respective areas. By showing the management how they can track HR progress one creates demand which would stimulate the HR team to start using the HRIS system to provide such information to the management.

This will be an ongoing challenge but one could look at having an annual refresher and quarterly reporting requirements to ensure that the date is being accessed and use to inform decision-making.

Plans for Next Quarter

Our plans for the next quarter include continuing to support the HR department at LMS to populate the report and incorporate any further recommendations and improvements. We further plan to continue to sensitize the management at LMS to the advantages of decision-making with data and what they could expect and request from the HRIS system.

We further envision rolling out a similar approach to AMS once their HRIS system is fully functional.

2.10.2. Human Resources Information System (HRIS)

IntraHealth's focus for HRIS activities during the previous year was ensuring the MoHSS has access to timely, accurate, and reliable data on the status of HRH information as input to national-level planning, policymaking, and decision-making. In previous years, IntraHealth worked with MoHSS to implement and roll out their human resources information management system (HRIMS) to all 13 regions in Namibia. Last year, Office of Prime Minister (OPM) began to replace the HRIMS with HCMS and IntraHealth assisted the MoHSS to ensure the HRIMS data were migrated successfully. This year, IntraHealth have been working with MoHSS to operationalize Human Capacity Management System (HCMS) and use it to make evidence based decisions.

The three mission facilities (CHS, LMS, and AMS), the Health Professions Council of Namibia (HPCNA), and the National Health Training Network (NHTN) were the stakeholders identified by the MoHSS. They currently share data manually and IntraHealth provided technical assistance in order to strengthen their systems and processes to ensure they have accurate and reliable data on registered health professionals and pre-service trainees that can be shared with MoHSS to provide input to a national Human Resource Information System (HRIS). Staff at FBO's is not considered public sector servants and are therefore not captured in the HRIMS or HCMS. To address this, we have implemented iHRIS Manage for LMS thus far and have just started the implementation process of iHRIS Manage at AMS, Odibo Health center. We will implement the system for CHS in the first two quarters of the new financial year.

We have completed gathering and documenting the user requirements of the HPCNA. We have also finalized the procurement and installation of IT and networking equipment for CHS and AMS.

iTECH's TrainSMART system is currently being used by NHTN to track HIV in-service trainings; therefore, there is a need to ascertain the system's reach and to determine how the system is meeting NHTN's requirements. Additionally, it should be determined if it can be expanded to also track pre-service training and the management of students enrolled for pre-service training.

Accomplishments & Successes

iHRIS Manage Usage for Onandjokwe hospital

At the beginning of this financial year, IntraHealth completed the iHRIS Manage implementation for Onandjokwe hospital, which is an FBO facility belonging to the Lutheran Medical Services (LMS). Throughout the year, IntraHealth provided technical assistance to LMS to conduct data quality assessments to ensure they can place reliance on their system. Feedback from the Chief HR Practitioner, Lazarus Amashisa, is that the system has improved transaction speed, accuracy and efficiency in the processing of daily business transactions. They are currently using the system mostly for enquiries and to support the monthly claims of employees' salaries they have to submit to MoHSS that funds 100% of their salary costs. They use the staff movement reports and the current staffing reports to support their claims. These reports show the total number of staff MoHSS has to pay salaries for as well as the details of the movements namely number of resignations, dismissals, terminations, retirements or newly appointed staff.

The system also helps them to fill vacancies quicker, as they can run a report that will show all the vacancies. They use this report to facilitate discussions at management meetings to prioritize which positions need to be filled urgently thereby ensuring they fill critical positions first.

The Nurse Manager of Onandjokwe hospital has expressed the need to track and monitor the leave patterns of their staff. The iHRIS team has therefore started working on customizing the leave module to enable LMS to capture the leave taken to enable them to track leave patterns and ensure all staff have equal opportunity to take leave.

HCMS training for MoHSS regional offices

During the 4th quarter, IntraHealth assisted MoHSS to complete the training for 2 of the remaining 3 regional offices. This brings the total number of HR staff trained on HCMS to 70 for the year.

The training used the HR process document developed with the assistance of the HRIS Advisor to train users on how to capture new appointments, update staff members' details and capture movements of staff members. IntraHealth covered the travelling and accommodation costs of a data capturer employed by IntraHealth but seconded to MoHSS. He assisted a senior HRP of the MoHSS in conducting the training sessions and in conducting data quality checks on the HCMS.

MoHSS has lost a lot of ground with the switch over from HRIMS to HCMS due to the network that was not able to support the new system. Therefore, although 9 075 of 9 361 records were migrated in May 2012, HR practitioners could not be trained on using HCMS until after the network was increased

almost a year later in May 2013. As a result, data completeness of HCMS against the MoHSS payroll has decreased from 88% at the time of migration to 47%. IntraHealth will continue to work with MoHSS to increase this percentage again so that reliance can be placed on the HCMS data.

Health Professions Council of Namibia

IntraHealth subcontracted the services of a professor at the Polytechnic of Namibia to assist in conducting the user interviews of the 5 councils namely Allied health, Pharmacy, Medical and Dental, Nurses and Social work and Psychology and 5 departments namely Legislation, Legal services, Records and Data Management and Finance and Administration. In total 19 users were interviewed and the team documented their current usage and challenges in using their current Records and Data Management System (RDMS).

Some challenges with their RDMS identified thus far include:

- There is no reporting system that users can use to run reports. Instead data is exported to Excel and pivot tables are used to produce statistics. Users however do not feel the statistics produced in this manner are accurate and there are users that are not able to use pivot tables to generate statistical reports.
- Most users are only able to query the system and cannot update records themselves. Instead they have to raise a manual request for data to be changed, a process that sometime takes long and result in outdated contact information of health workers on the system which impacts on sending timely reminders for renewals to heath workers.
- Not able to capture deployment information namely sector, region and type of health facility where health workers are employed.
- They have no first-line support for their RDMS and is totally reliant on an external consultant to provide even basic support on the system.

Stakeholder engagements

A Stakeholder Leadership Group (SLG) was initially formed in 2008 with iTECH chairing it. MoHSS has now indicated that they would like the restructuring committee to become the HRH observatory which effectively makes the SLG redundant as the HRH Observatory will be responsible for providing guidance on HRH related policy issues. Since terms of reference still need to be developed for the HRH Observatory, we are not clear at this stage how the HRIS project will fit into this.

We will continue working with the HRM directorate to receive guidance on which stakeholders to engage with to support the objective of creating a national database for the health workforce domain.

Other Accomplishments & Successes

We advertised and selected an IT vendor to supply and install 28 computers, 10 network printers and local area network points for 4 CHS facilities and 1 AMS facility. This IT infrastructure was necessary to enable the implementation of iHRIS Manage for the FBOs to allow them to track and manage their health workers.

Following up on an initial systems analysis that IntraHealth conducted for HPCN, we presented our high-level findings and agreed to provide assistance to document their requirements, conduct a gap analysis, and make subsequent recommendations.
We have appointed an HRIS Systems Analyst to guide and mentor the HRIS trainees on the work required to complete the iHRIS Manage customization and implementation for AMS and CHS. He will also be responsible for tying all the individual data sources together for the design and implementation of a national database for the health workforce domain.

Challenges, Constraints, and Plans to Overcome Them

We are finding that our trainee HRIS developers do not have the necessary experience to implement more complex reports and customizations required for iHRIS Manage. As a result, it took us a long time to complete the iHRIS Manage customization and implementation for LMS. The recently hired HRIS Systems Analyst have already made a marked improvement through providing more direct support and guidance to the trainees to address the areas they need more assistance in. One trainee and the systems analyst attended an advanced training academy on the iHRIS suite of products in August 2013. These interventions have assisted us in building the necessary local skillset to support iHRIS Manage. We will continue to monitor and address further challenges as they become apparent. We envisage that should we start to use iHRIS Qualify, Train or any of the other modules of the iHRIS suite of products, we might need to build additional capacity.

We have not completed the user requirements gathering for NHTN due to the HRIS team being fully engaged with other activities and the HRIS systems analyst position only being filled the last month in the quarter. This activity has been postponed to next year.

Despite continued follow-ups with OPM via MoHSS the additional reports and a gap in HCMS where users are unable to update staff movements with the reason for the movement has still not been implemented. This is a big challenge to the MoHSS' ability to use HCMS to inform HR-related policy and management decisions. IntraHealth will continue to engage with OPM through MoHSS to offer assistance to address the gaps identified in HCMS and to consider piloting an open-source reporting software to alleviate the reporting challenge.

Plans for Next Quarter

- Finalize and obtain approval for the documented user requirements for HPCNA
- Using the approved user requirements, continue to assess HPCNA's current Records Data Management System to determine what challenges they are facing that prevents them from

using their RDMS for evidence based decision making. We will do this by providing technical assistance to assist them in evaluating options to address the challenges through either modifying their current RDMS or identifying another system they can use to administer the health professions register. We will also assist them in identifying what skills are required to ensure they have first line support available for their RDMS to decrease their reliance on external consultants and build internal capacity to develop and run reports.

- Complete the iHRIS Manage installation and training for AMS at Odibo Health Center.
- Demonstrate iHRIS Manage to CHS and gather their requirements to customize the system for their use.
- Provide technical assistance to MoHSS to rollout the online leave approval process via HCMS to all 13 regions.
- Meet with MoHSS and the Emoc team to develop the plan to develop and implement an eLearning module for parts of the Emoc training.

2.11. Program Area 12: Strategic Information

2.11.1 Monitoring and Evaluation

IntraHealth's approach to M&E places great emphasis on capacity building of partner organization staff to interact with and manage their M&E systems and use the data for program improvement. The M&E team continued to assess and strengthen M&E at partner facilities in collaboration with MoHSS and partner national office staff. The main focus for this financial year was in line with the integration plans of the MoHSS: to assess the capacity of facilities on their ability to continue M&E functions without IH support, and then provide recommendations to the MoHSS and facilities.

During the past year, IntraHealth's M&E team continued to work with staff at the MoHSS and partner organizations to ensure the smooth integration of FBO partner M&E activities into the MoHSS. This included assessing the partner M&E systems using the PIA approach, a rapid data quality assessment, and data collection tools, as well as strengthening the capacity of partners in using strategic information. Helping partners to improve the quality of data; data collection, data use, and report writing, has also been a priority. IH continued to implement processes to ensure monitoring of the quarterly and annual work plan, of the activities conducted by various facilities, and the evaluation of performances and results.

During this period, the IH PMP had undergone adjustments and revisions by adapting to the data needs of the different stakeholders and the new Capacity Plus agreement in order to better support the decision making process.

Accomplishments & Successes

- During the last quarter, the main focus was on ensuring smooth integration of partner organizations' M&E functions and staff into the MoHSS.

- Support has been provided to the partner organizations during the AA closeout process and reporting. IH organized workshops for all partner organizations on the reporting requirements for the AA and provided support to facility staff to complete the final AA reports as well as data templates.
- During the last year, IntraHealth provided support to a combined team of the MoHSS and IntraHealth WISN activities. The support included reviewing the data collection tools, ensuring data quality during data collection and entry and report writing.
- The Rapid Data Quality Assessment (RDQA) started during the 3rd quarter with a visit from the M&E Officer from the IH CH office. RDQA was completed in Q4.
- The M&E staff has been working on reviewing and updating the AA PMP , including Capacity Plus reporting, indicators and benchmarks. The M&E staff has been supporting the staff in the office to ensure reporting for Capacity Plus and USAID (Washington).
- Partner M&E system strengthening
    - Partner staffs were provided with onsite training on narrative reporting and indicator template completion.
- Partner capacity building
    - IntraHealth continued to provide technical assistance to CHS's newly appointed M&E Officer. The focus of this technical assistance was on basic M&E, reporting requirements, and indicator data for their all programs.
    - IntraHealth also supported partner staff on ePMS, specifically how to clean data once reported from the health facilities, generating data for PEPFAR indicators, and producing other care and treatment reports for program planning and evidence-based decision-making.
    - LMS received technical support for strengthening their care and treatment reporting system, resulting in immediate improvements.
    - During the year, the M&E staff provided training on data entry and reporting for ePMS as well as HIVQUAL for staff at partner organizations in collaboration with the RM&E subdivision at the MoHSS.
- Electronic Patient Monitoring System
    - During this reporting period, work on the planned update of ePMS is nearly complete through cooperation with MoHSS' Directorate Special Programs (DSP), IntraHealth, and the consultant. DSP has finalized the update on the patient uptake forms for both adults and pediatric patients enrolled in HIV care and HCT.
    - IH's IT expert seconded to DSP continued to work on the development of the ePMS, the ePMS technical manual and to provide ICT technical assistance to the MoHSS.
    - The site level ePMS version has been finalized; IH will continue providing support to the MoHSS to print the revised patient booklets and supported training to the data clerks on the revised version of ePMS during the 4th quarter and into the 1st quarter of FY14.

Challenges, Constraints, and Plans to Overcome Them

- During the year, most nurses, doctors, pharmacists and pharmacy assistants were transitioned into the GRN/partner organization payroll. However the integration/transition process has not been easy and has negatively impacted some M&E activities because of the lack of program management oversight at facilities:
    - Most key personnel for M&E at the partner facilities have resigned over the year with little or no handover and no other staff to take over the M&E activities/reporting process;
    - CHS national office staff contracts ended during the year; they had been responsible for providing support to four of the six IH supported facilities and at times the facility staff have received little or no support;
    - Since all nurses and doctors were supposed to be integrated into the partner organization payroll, all facilities were informed to stop reporting for all programs except for HCT and PwP. However, LMS absorption of nurses by GRN did not take place in September as planned and caused confusion for the quarterly reporting process. Up until the last month in the 3rd Quarter, it was not sure which partner facilities would be reporting on which programs. This has resulted in incomplete or unreported data for multiple programs.
- Most of the clinical staff has been transitioned onto the government payroll and M&E activities remain a challenge since doctors and nurses will be rotating within the facilities. IntraHealth continued to provide M&E technical support to the facility staff in order to ensure that M&E systems and quality of data is maintained.
- Facility staff reporting needs additional support from the MoHSS and IH. This should help to improve the quality of data collected and will enhance ownership, involvement and commitment.
- During the 3rd quarter, the M&E Advisor and M&E Officer and various program officers resigned from IH, which negatively influenced the M&E activities at the IH office. This also posed a challenge to the RDQA team from CH, as well as the construction of this quarterly report. Fortunately, relationships with the resigned M&E team are strong enough to allow limited continued assistance when necessary.
- Interviews took place for a new M&E Manager in Quarters 3 and 4.

Plans for Next Quarter

In the program's final year (No Cost Extension and Capacity Plus), the main focus will be on improving M&E skills and ensuring a smooth integration of partner M&E activities into the MoHSS.

- The RDQA Final Report from the CH team was completed and will be shared with relevant staff and partner organizations.
- The appointment of the new M&E Manager will be a priority during this quarter as it has been difficult hiring a senior M&E for almost half a year. An alternative consideration would be to hire a consultant for the remaining period.
- Provide continued support to LMS to report for all programs until complete integration of doctors and nurses has been achieved.

- IntraHealth will support the MoHSS to conduct training and mentorship of the RM&E, RMTs and facility staff on updated ART data collection tools and ePMS.
- To strengthen partners' capacity in supportive supervision, IntraHealth will conduct M&E mentorship visits to partner offices, and continue holding quarterly M&E partner meetings for feedback and discussion of M&E issues.
- The HCT client register has already been integrated into the MoHSS system. In collaboration with the MoHSS, IntraHealth will work with the HCT team to ensure the integration of other data collection tools, such as the client intake form and New Start HCT system.
- Provide technical assistance to partners to implement data quality and verification plans to ensure data accuracy and develop approaches to correct discrepancies.

2.13 Issues with Data Quality

To ensure the accuracy, objectivity and reliability of data used to measure the performance of IH program activities as well as the sources and collection of data on the performance indicators, the PMP incorporates a data quality evaluation and management. This specifies the responsibilities of each implementing partner in data collection and information management.

In June and July of 2013, IntraHealth used the RDQA tool, timed near the project's closeout, to determine the M&E system's ability to collect and report quality data at all levels and identify gaps prior to writing the Final Report at the end of the project. The M&E structure, functions and capabilities; data collection and reporting forms and tools; data management processes; and evidence-based decision making components (five of the six components) all scored high for most programs. However, the RDQA team concluded that there are some gaps that need to be addressed, including:

- The RDQA team observed both under- and over-reporting, caused by a variety of factors including data entry errors, limited understanding of the indicators and how they are collected, and missing reports
- Written guidelines for data collection, reporting and systematic back-up were not available nor accessible for the majority of programs
- Data collection forms and tools for certain programs were not systematically used by all health facilities which affect accurate reporting.

RDQA report recommendations will be used to improve partner data collection and reporting systems, as IntraHealth transitions away from providing service delivery support. IntraHealth will play a key role in working with MoHSS to ensure that transition is smooth.

The project has been routinely generating quality data and the IntraHealth M&E team have provided partner organizations with coaching and mentoring on data collection and ensuring data quality, record-keeping, program reporting, HMIS systems, and other quality-improvement initiatives. IntraHealth is implementing the quality in, quality out (QI/QO) model with all partners to ensure data gathered is valid, reliable, accurate, precise, and timely.

IntraHealth continues to provide technical assistance to improve data quality, including regular data quality checks to confirm appropriate data management systems are in place and verify the quality of

reported data for key indicators at sites. On a routine basis, IntraHealth implements the following to ensure that the data received from partners and reported to USAID is of high quality:

- Provide routine technical support and mentorship to the partner organizations to ensure problems with data are adequately addressed.
- Support facilities to make sure that at the end of each month, discrepancies between the data entered in the electronic and the paper based systems are identified and addressed at the facility level.
- In the case of staff rotation, IntraHealth will provide technical support to ensure that health workers in HIV/AIDS program settings are trained and the quality of data is sustained.
- The IntraHealth M&E staff assists partner organizations to routinely verify data reported monthly, and provide feedback to the reporting sites.
- Quarterly data quality checks are conducted for program data.
- Data submitted to IntraHealth are checked by district coordinators and program managers at site level and program managers at national level before submission.
- The VCT & ART electronic systems have built-in data quality checks. The data clerks and site managers confirm quality and consistency.

Specific concerns with the quality of the data provided in this report:
Program staff is being integrated into the government payroll and M&E activities remain a challenge to the under-staffed partner organizations as they are overloaded with other day-to-day responsibilities. M&E staff morale is low due to uncertainties surrounding their integration into the GRN payroll despite reassurance from IH that MoHSS intends to absorb them. Also, key partner organization staffs responsible for reporting have resigned.

How IntraHealth is improving the Quality of Data
IntraHealth continues to improve the quality of program data. IntraHealth and partners continually identify ways to improve data collection, analysis and utilization:

1. Work with partner facilities to routinely conduct data quality and verification exercises to address data issues at their respective facilities.
2. Encourage facilities in regular data use, which will increase their understanding of the value of high-quality data.
3. Continue to strengthen the involvement of the district coordinating team at the facility level, especially the PMO, matron, and PHC supervision in HIV M&E activities.
4. Help facilities to integrate M&E activities and monitor their M&E strengthening action plans.
5. Provide continued support to LMS staff to continue reporting on all programs.

Environmental Issues

During the last year, in compliance with USAID environmental requirements and regulations as per the 22 CFR 216 integrated into ADS 204.5, IntraHealth and the project-supported sites conducted the following activities:

- Triaged coughing patients to minimize risk of exposure to TB and other infectious respiratory conditions.
- Provided patients and staff in MDR-TB wards with N95 masks.
- Counseled TB patients in the special rapid test rooms in or near the TB wards.
- Used open areas, such as verandas, as patients waiting areas to improve infection control.
- Supervised staffs to adhere to appropriate waste disposal, including sharps, medical waste (including foreskins from MC and placentas from deliveries), and condoms used for demonstrations in counseling and testing.
- Observed safety measures while transporting waste generated from outreach services.
- Provided technical support to ensure all health workers with occupational exposures to through needle stick injuries or other direct mucosal exposures, received appropriate PEP and were tracked

Success Stories (optional)

During the year, IntraHealth was able to develop several different publications that help highlight the good work begin accomplished with USAID's support. The full write up of these stories are attached.

- The long road to Rundu – example applying EMOC training
- Namibia's front line HIV counselors
- iHRIS Manage usage at LMS
- National WISN
- Integration of LL/CL and CCN